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## ORIGINAL LECTURES.

### A MODIFIED OPERATION FOR CYSTOCELE.

*Remarks before the Cincinnati Obstetric Society.*

By THADDEUS A. REAMY, M.D.

(Specially reported for THE MEDICAL NEWS,

By James M. French, M.D.)

GENTLEMEN: Contrary to the custom of the Society, I will make a verbal instead of a written presentation of the subject assigned me. I do not desire to offer a new operation, but only a modification of the operations already proposed for the relief of cystocele. I will not go into the causes of cystocele any further than to bring forward the facts necessary to explain the operation proposed.

It is well known that Scanzoni advocated the doctrine that cystocele may exist primarily without a prolapsus of the anterior wall of the vagina or other conditions of the vagina to cause it, the vaginal prolapsus being secondary and dependent upon the cystocele. He supposes that in these cases there is spasm of the fibres of the body of the bladder, while the neck is quiet—the urine thus forced to remain in the fundus, dilating it and producing the cystocele. This view is adopted by many, but is discarded by most authors.

Cystocele is rarely found in women who have not borne children. It is rarely disassociated with deformity of the vagina. The walls of the vagina in such cases have been altered in their conditions, in their relations, and in their thickness. In short, we have a prolapsus, and this is especially the case if there is any great degree of cystocele. The bladder is to a great degree held in its position by the firmness and supporting power of the vaginal walls, the relations being intimate, and so long as the vagina maintains its proper strength, its proper size and relations, there can be little or no cystocele. It is now stoutly denied, especially by my friend, Dr. Frank P. Foster, of New York, that the vagina or perineum have anything to do in supporting the uterus. Be this as it may, it is clear that loss of the perineum and associate deformity of the vagina, play a very important rôle in cystocele, and this fact must be considered both in a study of causes and devising methods of treatment. Of course, we all know that generally in these cases one of the most troublesome symptoms is irritability of the bladder, although even this is held in question by some. I need not dwell longer on this part of the subject, as I am speaking to practitioners, not to students or beginners.

Now, the question is, What can be done for the relief of this condition? and it was to illustrate the operation for this that I brought the subject before you this evening. We know that the first and simplest methods which are employed are those which aim to hold the bladder in place by pessaries, etc. Dr. Skene

has devised a pessary which is one of the very best within my knowledge. There are many others with which, of course, you are familiar. In simple cases these devices do very well indeed; but even in such cases they seldom accomplish a cure, operative measures becoming a necessity. I am well aware of the fact that in any surgical measures yet devised, we have not in all cases, even permanent relief, much less cure. Indeed there are many who deny that permanent relief is obtained by any surgical or other measures in any case. With these views I cannot agree. My own clinical experience fully warrants me in dissenting. In almost every case where there is not serious uterine prolapsus, as well as prolapsus of the vagina and bladder, permanent relief may be expected provided the surgery be well done. But of course in cases where there is perineal loss, with vaginal deformity and prolapse, the operation for cystocele proper must, in every instance, be associated with or supplemented by perineorrhaphy and, if necessary, colporrhaphy. The fallacies which are held by so many on this subject, in my judgment, have their origin chiefly in the erroneous conclusion that because it is difficult, and in many cases impossible to cure a uterine prolapsus, it is, therefore, impossible to cure a vaginal prolapsus, forgetting that the former frequently exists for a time without the latter; although it must be recognized by all that sooner or later the uterine displacement will generally follow as an inevitable result of the dragging of that organ by the prolapsed vagina and bladder. It is true the weight of the vagina is not great, though under such circumstances it is generally increased above normal, for subinvolution of the vagina is almost uniformly present; nevertheless the weight is quite sufficient to cause the evil. It is not the amount of weight, but the direction and character of the dragging that finally accomplish the bad results. I may as well here as elsewhere declare my belief that, in addition to this dragging upon the uterus, there is the negative influence: absence of such support as the normal vagina gives to the uterus. Unpopular as this view is at the present day, I still believe that this support is not wholly a myth, although, in former time, it has unquestionably been overestimated.

But as to surgical methods, I shall only refer to those proposed by Dieffenbach, Sims, and Emmet, though there are many others of merit. The method of Dieffenbach, as all know, consists of an elliptical denudation from the anterior vaginal wall, closing the edges by suture. When well done, union is firm, and in simple and mild cases the result is satisfactory. But in bad cases the extent of denudation necessary causes deformity of the vagina when the cure is effected. Sims's method consists of an elliptical denudation as in the method of Dieffenbach, but the whole surface is not denuded, only a narrow strip, forming the ellipse, the centre being undenuded thus (see blackboard). There are two important objections to this method. First, at

the middle of the ellipse especially, so great is the tension upon the sutures, that they are liable to cut out at once. Secondly, when union is secured, the paths of denudation and of union are so narrow that in a short time the newly united tissue will have stretched under the tension to which it must be subjected, and the benefits of the operation are lost. These are just the same objections which exist against both Sims's and Emmet's operations for prolapsus of the posterior vaginal wall. The principles are the same, no matter which wall is to be treated.

For Emmet's latest operations, I must refer you to the figures in his book.<sup>1</sup> It will be seen that the lines of denudation follow no geometrical rules, and cannot be described. Two-thirds of the figure next to the uterus are in form not unlike the ellipse of Sims or Dieffenbach. The remaining portion is crescent-shaped with its concavity toward the urethra. These lines are approximated and union occurs. The old objections again arise. First, there is a portion in the centre undenuded, so that should union occur the tissues must yield in time. Second, as this distinguished author himself confesses, union at the triangular angles is difficult to obtain, a second operation often being necessary.

This last objection, Dr. Emmet thinks, he has now succeeded in overcoming by another modification which I do not detain you to describe, as you have access to his better description in his valuable text-book. It is sufficient for my purpose to say that in the modified operation one crescentic line of denudation crosses the base of the urethra with its convexity toward the meatus. Another similar line crosses the upper portion of the vagina with its concavity toward the uterus. This author, with the candor for which he has such just reputation, admits that he has tested the method in but few cases and cannot yet tell how it will stand the test of clinical experience. I must state my objection that this method also leaves the central portion of mucous membrane undenuded, so that it seems probable that the parts will yield.

As to my own method, I have followed it in public hospitals and in private practice for eight years, with very satisfactory results in favorable cases. I think it has some important advantages.

For the operation, the patient is placed in the extreme lithotomy position, an assistant holding each lower extremity, the posterior vaginal wall held back by Sims's speculum. The tissues are caught up by a small double-toothed tenaculum forceps, and the cutting is done with long scissors, sharp-pointed, curved on the flat—the same as used in perineorrhaphy.

A constant stream of water at 100° F. is allowed to play on the field of denudation, the water being carbolyzed. This controls hemorrhage and keeps the field clear.

I beg to refer you to the imperfect figure which I now draw on the blackboard, which explains the direction and extent of denudation, also the method of suturing and closing.

Fig. 1 illustrates practically the direction of the denudation, but of course this will vary with the amount of cystocele you are dealing with and the

amount of tissue you desire to remove. The denudation is also modified in width or length as each case requires. If you desire to cut deeply, you must remember to avoid wounding the ureters as you denude

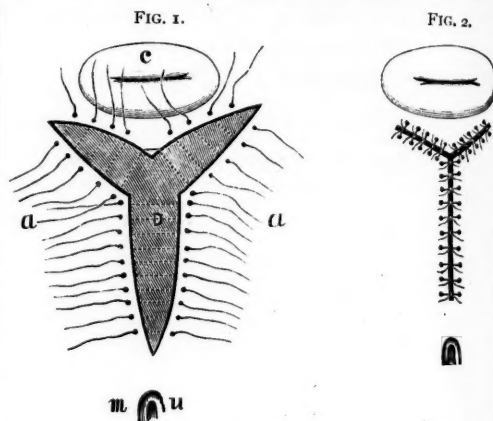


FIG. 1.—D. Denuded surface. The lines of denudation are sharply defined, so that when the sutures are tightened they shoulder against each other, and firm union by first intention is secured. Ordinarily no cicatricial tissue is found in the line of union.

a. This suture approximates the three angles.

c. Cervix.

m. u. Meatus urinarius.

FIG. 2.—Position of parts after sutures are tightened so as to approximate the edges bounding the field of denudation. Sutures tied.

the lateral branches. There is, however, substantially no danger of this unless you carry the arms some distance out beyond the cervix. I have never encountered accident, but theoretically the danger does exist. I will call your attention later to the importance of carrying the denudation deep, and sometimes even into the bladder.

With regard to the position of the ureters, you will see by looking at plate No. 3, by Savage, that the relation is given. The bladder-wall is cut away, showing the relation of the cervix to the entrance of the ureters into the bladder, and it shows you the direction followed by the ureters as they enter.

The inquiry as to results might be stated as Thomas puts it. He says it is not material what direction the denudation may take, provided you get rid of sufficient redundant tissue (or words to that effect), and take up the pouch that is present, for it will contract from all directions. But you can readily see that the uterus is one fixed point, the meatus another, and the greatest amount of redundant tissue is situated just forward of the cervix. Now you can see a step further, that if you carry the arms of your denudation on either side of the cervix, the direction of the contraction will be directly in harmony with the original construction of the parts, and that the contraction, if you get union, will be in the very direction in which you desire to get support. Further, in this method the tissues can be safely subjected to greater traction than they can bear in any other method of procedure. In the clinical use of the

<sup>1</sup> Principles and Practice of Gynecology, third edition, pages 362-3.

method you will find that you do not have to denude so large a field in order to get sufficient contraction, or, rather, no one path of denudation is so wide.

Now a word with regard to the depth of the denudation. As you come down toward the urethra, you can denude very deeply, but it is not necessary to go so deep there, as it is further up towards the bifurcation of the denudation. Here, however, if you simply take off the mucous membrane, and do not go through the muscular tissues of the vagina into the cellular tissue between vagina and bladder, the operation will fail, and because you can denude so deeply with safety by this plan is one of its chief advantages. In two cases in which I desired to cut deep, I have opened the bladder and formed a vesico-vaginal fistula, but I closed it up at once with the sutures of the operation for cystocele, and nothing untoward occurred. Denude deeply, for the more deeply within limits the more certain you will be to get good results. As already stated, at the upper extremities of the denudation it is better not to go too deeply, on account of the ureters; but that danger, as already stated, I do not regard as great.

The sutures are placed in much the same manner as in the other operations, only it is important that they be placed close together. I usually put as many as eight to the linear inch of the denudation. It is important that the suture marked "a" be placed as represented in the drawing. This is for the purpose of drawing the three arms of the Y together, when the stitch is drawn tight. The consequence is that the tissue is pulled forward and backward and the uterus being more fixed than the other parts, the tissue is put upon a stretch transversely also. It is immaterial whether the threads show on the denuded surface or simply split the tissues in the middle of the denuded surface. Even if the suture should go into the bladder, it will do no harm. It is important to get the border surfaces united perfectly by first intention.

The kind of suture I am using is the so-called silk worm gut, out of which fish-lines are made. It is really made of the intestines of a fish, it is an animal ligature, and you can with ease render it perfectly aseptic. It is strong enough for any purpose of this sort. You can draw it with almost your entire strength without breaking it. It is prepared for use by cutting the kinked ends off with the scissors, and throwing the rest into a carbolic solution—a ten or fifteen per cent. solution in warm water, and in a half hour it is ready for use. Tie two or three knots, or it may come undone, but you may cut the ends short or long as you please. Its advantages are: first, it is very smooth; you can arm the needle with it directly and it will not kink like a silver wire. Second, it has strength enough for any operation of this kind, including trachelorrhaphy. Third, if you render it antiseptic, my observation has been that no more suppuration will follow than follows silver wire. In this I agree with the opinion of my friend, Dr. Sutton, who has used this suture many times more than I have and who first advised me to employ it. Fourth, although the ligature gets soft enough in the preparation for you to tie it with ease, yet it gets no softer, although permitted to remain in the tissues three or four weeks, thus affording support as to position of tissues equal to that of silver wire. Fifth, although an animal ligature, it is not absorbed, and remains like a wire for weeks.

Sixth, you can leave the cut ends in the vagina, for they will not jag the tissues, and even a No. 28 wire will jag if the ends are cut short.

After the operation the patient must be kept in bed and a self-retaining catheter kept in the bladder, constantly, for eight or ten days until union is complete. This, I regard as essential, since the distention of the bladder, which may not prevent union, will nevertheless prevent the union from occurring with the field of the operation in the contracted state so favorable to good results. These remarks will impress you as all the more important, if you recall my recommendation always to carry the denudation through the vaginal wall, at least near the centre.

I have operated after the method proposed in fifty cases, and think my experience warrants the claim that it possesses the following advantages:

1. Simplicity, ease of execution.
2. Less width of denudation is required at any given point, in order to secure the necessary contraction after closure than in other methods.
3. The deep denudation necessary to cure, in all cases, can be done by this method with greater safety.
4. Since tension upon any one line of the operation after union is less than after other methods, and since the deep denudation causes firm union, the good results are likely to be more permanent.
5. After cure, the vaginal orifice and entire anterior wall of the vagina will conform more perfectly to the original.

In closing the discussion which followed the above, DR. REAMY said: I shall have to dismiss the question that has been raised concerning the propriety of making a perineorrhaphy or a colporrhaphy posterior, by simply calling your attention to the fact, in the beginning of my remarks, I stated that what I should say had reference only to the operation for cystocele, without any of the complications, except prolapse of the exterior wall of the bladder, and I referred to the other complications only so far as to be understood. I have frequently made my operation, however, in connection with perineorrhaphy and posterior elytrorrhaphy. Of course, no man would make this operation alone except for pure cystocele, or cystocele with prolapse of the anterior vaginal wall, which is also cured by the operation. No treatment is complete unless you restore the vagina. It is advisable, however, when the posterior operation is to be done, and plenty of time is allotted to the operator, and where he can control the patient, to make the operation on the anterior wall first; then, as soon as the patient has recovered, and before she is out of bed, to make that on the posterior wall.

With reference to the method of Dieffenbach, for which one of the speakers has expressed preference, with Emmet's modification, if we take out sufficient tissue, in the elliptical form, it does well, provided the case is an uncomplicated one. To show that it is defective, however, we have but to consider what will be the shape of the cicatrix resulting from the removal of an elliptical portion of mucous membrane in a bad case demanding extensive denudation. Will not every one agree that it is the highest type of gynecological skill to restore deformed parts as nearly as possible to their natural condition? In Dieffenbach's operation what do you do? You draw the edges of an elliptical



denudation together, and necessarily deform the vagina. The method disregards the form of the wall, and does not regard the constriction of the vagina where it goes forward to join the bladder wall. It makes a flat, straight surface. In addition to this it removes so broad a surface that to go deep is dangerous. The prime advantage of the operation proposed, on the other hand, is its simplicity, and the small amount of tissue removed. Still, if the two arms of the denudation are placed side by side, it will be seen that the amount of tissue removed is considerable. The apex of the undenuded surface between the arms is fixed to the anterior uterine wall, and the result is practically the same as if a much larger surface were denuded. No undenuded surface is covered up. The angles are so easily brought perfectly together that union readily occurs. The rule is to make the denudation wide or narrow, according to the degree of cystocele, and to carry the lower arm down far or only a short distance, according as urethrocele is present or absent.

In reply to the statement of a gentleman who thinks the proposed operation the same as that of a distinguished author named, except that the directions of the triangles are reversed, I remark that he is mistaken. First, the arms of the denudation are in different relations. Second, the central denudation in my operation, which runs longitudinally with the bladder, is complete—no undenuded portion—edge to edge. Finally, in this connection, it is eight years since my method was devised and done in a public hospital.

## ORIGINAL ARTICLES.

### COCAINE

#### IN THE TREATMENT OF THE OPIUM HABIT.<sup>1</sup>

BY J. T. WHITTAKER, M.D.,

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THE remarks which I beg to offer to the Academy are based upon the treatment of two bad cases of the opium habit, one treated without, and one with, cocaine, whereby I had the opportunity of contrasting the effects. This contrast was made all the more striking from the fact that the case treated with cocaine had been on a previous occasion treated without it, the conditions on the two occasions being about the same.

My first opiumphagist was a successful merchant who had fallen into the habit after prolonged use of the drug prescribed by his attending physician for relief of neuralgic pains. I shall not run the risk of wearying the Academy with details. This individual awoke one morning hemiplegic and hemianæsthetic, and it was the fright occasioned by these symptoms that led him to send for a physician. I found him a victim of confirmed morphinism. He had no less than five hypodermatic syringes in his various pockets (one in each coat-tail pocket), and was using the drug in this way in the quantity of fifteen grains per day. I undertook to cut the patient off at once, keeping him under close surveillance night and day, but symptoms of collapse with colliquative diarrhoea

set in on the same evening, so that I was compelled to resort to the use of opium with large quantities of brandy to save his life.

The treatment of this case was a three weeks' siege of more or less constant attendance on my part, and vigilance on the part of the nurses. The victim of delirium tremens could scarcely have suffered more intense torture of mind. At last, at the end of about three weeks, the patient was able to walk about, and in another week to take daily rides; but there was still occasional insomnia, much mental distress manifested in a whining, whimpering, scolding way, and there remained occasional attacks of irregular shooting neuralgic pains in the arms and legs, which were quite defiant to all kinds of treatment. The pains seemed always more imaginary than real, but they formed the basis of complaint. At last the wife of the patient, who was much of a hysterical turn herself, concluded to take him to the faith-cure in a distant city. A stay of a week seemed to be of so much value to several members of the family as to justify the importation of the establishment to this city *en masse*. This was accordingly done, and thus was a branch of this ever-recurring temple of credulity set up with us. The original importers of it finding it growing a too expensive luxury, broke with it finally altogether, and rapidly increasing failures in treatment soon broke it up. But whether from pride, or lapse of time, or, what is more probable, from increasing general health after release from the opium, the patient continued to improve, and remains, I am informed, in a fair condition of health after the lapse of a year.

My second patient was a young woman of good physique, aged about twenty-five, who had likewise been introduced to morphinism by use of the drug in relief of an obstinate neuralgia—at least this was her story. Besides this physical there were psychical reasons in her situation in life which made her a more easy victim to the allurements of the drug. This patient, according to her own statement, had taken never more than three to five grains per day, and always by the mouth. After several ineffectual efforts to stop the use of it at her own house, she put herself under absolute control at the Good Samaritan Hospital. The morphia was withdrawn at once. Two nurses were detailed to watch this patient by night and day. The suffering that set in by the end of the second day was extreme. Quinine was given freely, and chloral at night, but without effect. There was no sleep throughout the night. On the next day, for a profuse diarrhoea, bismuth was ordered in full doses, and for the total anorexia the simple tincture of cinchona. At night atropia was administered hypodermatically with the statement, for its psychical effect, that the solution contained morphia. The atropia produced no sleep whatever and by midnight the patient had become desperate. She pleaded for morphia continuously. The nurses, however, remained firm in their refusal. Forty grains of the bromide of potassium were then administered, but there was still no relief. The patient now tried a ruse which nearly proved successful. She pretended to fall asleep, whereupon the nurses, wearied by the watch of the previous night, fell into

<sup>1</sup> Being the remarks made in the opening of the discussion of the subject at the Cincinnati Academy of Medicine, June 29, 1885.



a real deep sleep. The patient now arose and began a search for her clothes, which had been secreted; failing to find them, she tied her bed-clothing by the ends and by means of this improvised rope slid down to the ground, ran across the street and was found by a passing policeman standing in her night clothes pounding upon the door of a neighboring drug store to awaken the clerk. By the time the hospital authorities became aware of her escape the officer had returned the patient to the gates of the house. It was then thought best to practise gradual withdrawal of the drug, and this treatment was effectually carried out, but not without great distress, in the course of two weeks.

This patient persisted in refraining from opium for three years, when, during an attack of pneumonia, her physician in a distant city prescribed it in relief of her cough, and started her, according to her own account, anew in the habit. So soon as she felt herself thoroughly addicted to the drug she came back to this city to make the effort to desist from its use. She was taking now but two grains a day, one grain morning and evening, but she had the manner and bearing of a confirmed *habitué*. She made two distinct efforts to break the habit at her house, during which time she took large doses of the bromides, of chloral (two drachms in one night), of atropia, of the fluid extract of coca, and, on one occasion, to secure the only sleep she had, she inhaled chloroform for an hour. These statements were confirmed by a friend who had procured the remedies, as also by the presence of the drugs in the room.

Two weeks ago she reëntered the hospital under the promise which I had to make that I would prevent any undue suffering—anything that approached her previous experience—by the use of a sufficient quantity of morphia. Upon admission she was given ten drops of a four per cent. solution of the muriate of cocaine every two hours, but as this remedy produced no perceptible effect by night beyond a slight flushing of the face, she was allowed an injection of morphia, one-fourth of a grain. She rested fairly, but slept none that night, and on the following morning began to show the usual symptoms of abstinence. A cup of strong black coffee braced her for a time, but by ten o'clock she was in a state of great nervous unrest. I now gave her hypodermatically ten drops of a ten per cent. solution of cocaine. The effect was very striking; within five minutes the agitation subsided, the patient seated herself in a chair—she had been walking the floor wringing her hands—and with a flushed face and brightening eyes she expressed the immediate relief she felt, and began quite an animated conversation. This state of exhilaration was continued for an hour and a half, at the end of which time the old nervous symptoms began to assert themselves, and in two hours she was as bad as before.

Not to protract too much this history of a single case, I may state that four such doses were taken in the next twenty-four hours, two more than I had intended, always with the same immediate effect, but each time of shorter duration.

After the last two injections she complained of

very unpleasant sensations in the chest—sensations of oppression—with a general feeling of distress, to such degree that she declared she would not have another injection. To this proposition I readily assented, as there seemed to be some failure in the action of the heart. These unpleasant sensations disappeared under the use of coffee and brandy, but the patient was by no means as comfortable as she had been after a dose of morphia. Except the quarter of a grain referred to, no morphia had now been taken for seventy-two hours. I left under the impression that the victory had been gained, but only to learn in the course of the same day that the patient, after some altercation with one of the attendants, had returned to her home. She sent for me in the afternoon and informed me that she had taken half a grain of morphia. I thereupon withdrew from the case.

Four days later I was again summoned to her house on another pretext. I found the patient entirely free from the influence of opium, so far as I could judge, and was called to prescribe for a severe diarrhoea from which she always suffered for a time when the drug was discontinued. She had not touched it since, she said, with an air of pride, and after the night's sleep which the half a grain had secured, she had really had no craving for it which she could not resist. I visited her daily for ten days thereafter, during which time she rapidly regained her color, increased her weight, and recovered her natural buoyancy of spirits. She was herself persuaded—and this was the opinion of her friends—that she had gained such an easy victory by the use of the injections of cocaine. Therefore I give the case for what it is worth. Perhaps it may be an incentive to trial of its value in cases where testimony may be more carefully weighed. From my own observations, I am convinced that cocaine alone is not a perfect antidote or substitute for morphia, but I feel sure that a faithful trial of it will show it to be the best auxiliary we have.

With the indulgence of the Academy, I will now venture to make some remarks upon the opium habit in general, more especially regarding its diagnosis, the tolerance which, as is universally known, is gradually established, the evils which finally ensue, and the most approved means of treatment in our possession.

For the more pronounced cases of this morbid condition we must take a passing glance at the Orient, where the opium habit prevails at all times, we might say, as an epidemic. The law which forbids the use of alcohol is largely responsible for the universal use of opium in Mohammedan lands. Some form or other of nerve narcotic seems to have become necessary to man, and this is the form which has substituted all others in the East. Then, other forms of religion, as that of the Buddhists, for example, impose upon their followers long periods of fasting and opium is taken to relieve the cravings of hunger. It is estimated that one hundred millions of Chinese are opium smokers. But the influence which is far more powerful in the East than either hunger or religion is the belief that opium has aphrodisiac properties. It is strange that this drug has come to be credited with

such effects when if there is any thing definitely settled regarding it the very reverse is true, as is seen among all its *habitués*. Some idea of the extent of the use of opium in India may be gathered from the fact that nearly two and a half millions of dollars are paid for license fees alone, many of the dealers in Calcutta, like the beer brewers in our own country, owning seventeen shops apiece. Richards made a series of extensive observations upon the opium eaters of India, 143 of whom had taken the drug from 10 to 20 years, 62 from 20 to 30 years, and 18 over 30 years, in quantities varying from two to forty-six grains per day. He remarks that when used in moderate quantity it produces no perceptible effects except anaphrodisia, and as regards crime its *habitués* compare very favorably with those of alcohol, as opium eaters are, as a rule, a law-abiding class. Further, that it contributes but very slightly to insanity, as the opium eaters thus affected constitute but 0.0007 of the population. Used in excess, it begets the same physical and psychical degradation noticed in other races. But the opium habit is unfortunately not confined to the followers of Mohamet, nor to the lands of the East. It has found its way extensively throughout Europe and is increasing every day with us. Allen Williams makes the astonishing statement in the British Encyclopædia that quite a million people in the United States are addicted to this habit and that though Chinese immigration has been brought to a stand, the number of *habitués* continues to increase. In Michigan one ounce per week is, he says, the average quantity used by each opiophagist. This statement would seem to bear the imprint of exaggeration if the physician may judge from his own observation, but it is contended by those who stand behind the scenes, or rather counters of our drug stores, that not all the truth is told. The victims who do become the clients of physicians, maintain that they have been introduced to the use of the drug in relief of pain. Physicians' prescriptions are filled and refilled continuously long after medical attendance has ceased or the cause for the use of the drug has disappeared. The victims of tabes, cancer, tuberculosis in advanced form, and other incurable diseases, furnish a certain but by no means the largest contingent of cases. The great percentage of cases is furnished by the individuals of neurotic temperament, of weak will power, or unfortunate surroundings.

The tolerance which is begotten to the use of opium has been known ever since the drug was used in medicine, which period antedates by many centuries the birth of Christ. We become familiar with excessive quantities in the treatment of peritonitis, tetanus, chole- and nephro lithiasis, mania, etc., but these quantities are equalled, if not exceeded by opium *habitués*. Thus Taylor reports that the average quantity of the English opiophagist is from 3 to 8 ounces of laudanum per day. Coleridge is said to have taken a pint a day, and it is reported of De Quincy that he took a quart a day. Disregarding these statements as lacking authentic support, I may cite the case reported by Husemann of a woman affected with carcinoma uteri who took at least 20 grains of morphia a day, and a similar case by Credé, whose patient took

52 grains a day. Jul. Beer reports the case of a woman affected with metritis and fistula, who often took 24 grains a day and who consumed more than a pound and a half of the acetate of morphia in the course of three years. Burkhart mentions a case of morphinism where the victim after long internal use commenced its administration subcutaneously with 30 grains, and later increased the dose. But the most famous case is that recorded by Albin Eder in the *Oesterreich Zeitschr. für prakt. Heilk.*, No. 33, 1864, of a preacher who had used the drug for eleven years. He commenced with the tincture, which he gradually increased to one ounce a day, then used opium in substance in doses increased from 18 to 160 grains a day. Thereupon he began the use of morphia at the rate of seven grains every 9 hours, which he increased some months later to 27, and finally to 45 grains.

When the condition known as morphinism is reached its signs are plain and easily discerned, but where but small quantities are taken there may be no outward manifestations of the vice at all. A growing irritability of temper, a spirit of fault-finding, a fretfulness over trifles, or a temporary exhilaration with its reaction of depression, an increase followed by a blunting of the usual sensitiveness, or a lack of delicacy and refinement, may be remarked by the closest relatives, but not perhaps in any suspected connection with the habit. There is no doubt that unless discovered by accident the great majority of these cases remain unrecognized until the more pronounced signs of the condition supervene with the gradually increased dose. Walle, of Hanover, who suffered in his own person, speaks of this as the first stage or phase of the condition. With the occurrence of the second stage ensue more distinctive physical and psychical signs which are easily recognized when once the suspicion of the physician is aroused. The body is usually bent, the gait is sluggish, all movements are slow and more or less uncertain; there are tremor of the hands, and muscular twitchings in various parts of the body. The face is pale or wears a yellowish or greenish cast, the expression is dull and heavy. The eyes are half closed, with slow drooping of the lids, to be often suddenly lifted and again to droop. The eyelids are red from frequent friction with the hands, which are also often brushed across the forehead. The pupils are contracted and irresponsive. There is more or less constant sniffing of the nose with occasional forcible sneezing and the discharge of a thin watery mucus. Characteristic changes are always to be observed in the teeth. This singular fact, first remarked by Combes, was communicated to the Paris Academy, April 28, 1885, by Rochard. It is noticed that so soon as the body becomes saturated with morphia the enamel of the opposed surfaces of the molar teeth begins to suffer. The process of decay next invades the premolars, and lastly the canine teeth to such degree as to give them a cup-shaped form. Caries of this kind being unattended with periostitis is not painful, though it runs a rapid course. Yawning, long, deep, and more frequent and protracted than when waking from sleep, is a quite characteristic sign. There is more or less complete anorexia with especial aversion to meats; the taste is

blunted or lost; the tongue is coated; eructations, vomiting, and borborygmus are frequent; There is constipation or alternate diarrhoea, with, in the former case, unusually long stay and straining at stool, and the occasional discharge of mucus and blood. The skin sweats profusely after the slightest exercise or after any disturbance of the emotions. The urine in consequence becomes scant and dark; albuminuria or glycosuria may develop (Loewinstein); and the bladder becomes irritable when not quieted by the immediate effects of the drug. Amenorrhoea is common in the female and aspermatism in the male. The sexual functions, though slightly stimulated in their cerebral aspects at first, become gradually more and more obtunded until they are entirely lost, both as regards desire with pleasure and capacity. The average number of children of the opiphagist is reduced to 1.11 after eleven years of married life (Richards).

With these physical are associated psychical traits equally characteristic. There is the same languor of mind as of body, expressed in the general lack of interest or inability to concentrate the attention. It is plain to see that the intellectual and moral tone of the individual is reduced to a lower plane. The opiphagist grows neglectful of family duties and social obligations, becomes careless and untidy in dress, inconsiderate and indifferent to the opinions and regard of others, entirely preoccupied with his own sensations. The flashes of consciousness or wit which in highly sensitive, poetic, or overwrought imaginations may even exhibit the scintillations of genius, become more and more fitful and further apart, to leave the gloom of life more palpable and permanent than before. It is easy to stray from the rigid requirements of science to the airy realms of rhetoric in describing, or trying to illustrate this sombre state and still keep within the sober bounds of truth.

The last stage of morphinism is reached when the stage of apathy gives place to the stage of excitement. Such tolerance has now been established that appalling doses are required to maintain the effects. The gait has become more and more impaired. Lewin speaks of a case where it became necessary to use a cane, and there are on record cases which presented the symptoms of ataxia. The main cause of the excitement is the exhaustion produced by loss of sleep, which has now become impossible under whatever dose. Whatever interrupted sleep is secured leaves no sense of rest or refreshment. The bed is found tossed about in the morning with the jactitations of the night. Under this condition the expression grows more and more anxious and excited, the face is haggard, the eyes sunken and shining, there are outbursts of genuine mania, or delirium occurs with hallucinations under which the patient sinks with a slow marasmus, or with a condition of profound melancholy whose end may be precipitated by suicide.

There is, probably, no victim to the opium habit in excess that has not at some time made some effort to discontinue its use, as there is no *habitué* to any, even the most innocent quantity, who does not look forward to the time when he will abandon it altogether. The class of people who become addicted

to opium, as to any vice, is precisely the class that abound the most in good intentions. But the desired result is rarely accomplished. The confirmed opium eater can never desist unaided, and cannot be always rescued permanently even with every assistance. Every failure in the attempt breaks anew the force of the will, or what fragments of it are left, until at last the victim surrenders with the resignation of despair. Recovery is, then, only possible by the substitution of the will of others. Absolute control, with perfect isolation, is therefore a *sine qua non* in the treatment of most of these cases. It becomes, then, a question whether or not the drug is to be suddenly withdrawn. The authorities are about equally divided upon this question, which had best be left to the judgment of the practitioner in the individual case; so much will depend in solving it upon the amount which has been taken, and the temperament and constitution of the individual patient. A gradual withdrawal entails much less severe, but more prolonged, suffering, and patients are much more willing to undertake a siege of this kind than to storm the citadel at once. In private practice, in the great majority of cases, there will be no assent on the part of the patient to any kind of treatment which does not promise decided assistance in the way of substitution, or so-called antidote, from the start. Patients who submit readily to sudden withdrawal, without conditions, and experience speedy cures, are cases of deception. They have the drug secreted about them, or obtain it from sympathizing attendants. Druggists, like saloon-keepers, who are very lenient in their supplies, easily overcome their scruples with the reflection that others will comply if they refuse.

Thus arises the question of an antidote. It is quite superfluous to mention here more than the names of the drugs which have enjoyed this reputation from time to time. Atropin, pilocarpin, muscarin, each possesses properties antagonistic to some of the effects of opium; and are hence, strictly speaking, antidotes in cases of acute poisoning by the drug. But none of these agents antagonizes the cerebral effects of opium, which constitute the chief suffering of the opium devotee. Chloral and chloroform, hyoscyamus, conium, etc., may force a sleep of a few hours, to leave the patient more wretched than before. The various bromides fail of even temporary relief. Strychnia, quinia or cinchona, capsicum, agents whose virtues have been vaunted in the treatment of morphinism, owe their reputation rather to transient indications they may meet than to any neutralization of effects. So far as real relief of the condition is concerned, none of the remedies equals in value prolonged warm baths, gentle friction of the surface, or the administration of a cup of strong, black coffee. I do not speak of the multitude of secret antidotes sold at large, and used in so-called "retreats." What virtue they possess is wholly due to opium. Large quantities of morphia are now exported to China for the cure of the opium habit. The powders are mixed with rice, and taken at gradually increasing intervals.

The true antidotes of opium being thus of so little use, search has been made in a different direction to find, not an antidote, but a substitute; and this investigation has been rewarded, to some extent, with



the discovery of the properties of coca, a drug which, while it does possess some antidotal qualities—mydriasis, for instance—possesses more analogous properties, especially as regards its action on the brain.

Coca, or more properly cuca, is a remedy comparatively new in materia medica, but its popular use is as old, so far as we know, as opium itself. In comparatively modern times the wood of the coca tree, as one of the red woods, has become an article of extensive commerce on account of its color; but, long before this period, the leaves were found in common use as a masticatory by the natives of various parts of South America. The tree grows spontaneously on the east of the Andes, but has been successfully cultivated in Bolivia. It is estimated that eight millions of people chew the leaves of cuca, which they carry in leathern pouches mixed with the ash of other plants, which alkali softens the leaves for easier mastication. Two to three ounces of the leaves constitute the average daily quantity for each individual; but this quantity is exceeded when extra labor is to be performed, or when new stimulus is considered necessary for extra-aphrodisiac effects. It is the universal testimony of all travellers that cuca begets a singular exhilaration, a feeling of buoyancy and light-heartedness, an increase of muscular strength, insensibility to fatigue, obtunding of the sense of hunger, a peculiar suppleness of motion, "long-windedness" at high altitudes, and decided stimulation of the genital sense. Garcilasso never observed any ill-effects from its use, and Van Tschudi remarks upon the good health and longevity of those accustomed to it. Markham says of it that it is the "least injurious, and most soothing and invigorating of all the narcotics used by man." Dr. Archibald Smith makes the statement that cuca, "when fresh and good, and used moderately," increases nervous energy, removes drowsiness, enlivens the spirits, and enables the Indian to bear cold, wet, great bodily exertion, and even want of food to a surprising degree, with apparent ease and impunity." And, though it has been accused of producing in excess tremor of the limbs and a gloomy melancholy, he has never seen a case of the kind in an acquaintance with its effects on all classes of people for many years. The article on this subject in the *British Encyclopædia*, which contains several of the remarks cited, quotes also from an apostrophe by the poet Cowley concerning coca:

"Whose juice suc'd in, and to the Stomach tak'n  
Long Hunger and long Labor can sustain;  
From which our faint and weary bodies find  
More Succour, more they cheer the drooping Mind  
Than can your Bacchus and your Ceres join'd."

The physiological effects of coca were first scientifically studied by Mantegezza in 1858, who showed that when chewed it keeps the teeth white, facilitates the process of digestion, and diffuses a sense of warmth over the whole body. The mouth, nose, and eyes become dry after its use and there is a decided increase of strength, of motility, and heightening of the intellectual faculties. The drug was used as a remedy for various forms of "dyspepsia" attended with pain, colic, enteralgia etc. In the following year, 1859, the first chemical analysis of the drug

was made by Niemann, who discovered the alkaloid cocaine, a principle which had the property, upon its application to it, of making the tongue almost insensitive. It is singular that although this observation was subsequently made by Carus, of Leipsic, who noticed also that the same loss of sensation occurred in the throat, both statements having been later repeated also by Fronmüller and Schroff, and that Aurep in 1880 noticed loss of taste as well as touch in the tongue, and loss of sensation in the skin after a hypodermatic injection of cocaine, it is singular that our knowledge of the range of the anæsthetic properties of cocaine should have been reserved to last year, when ensued the almost accidental discovery by Koller of the anæsthesia of the eye following the application of the muriate of cocaine prepared by Merck.

It does not pertain to our subject to speak of the local anæsthetic properties of cocaine which formed the subject of full discussion in this Academy a few weeks ago. Nor is there much to add regarding this active principle of the drug to what has been said already concerning the substance itself. Freud has just published (May, 1885) the results of his studies with cocaine, testing its effects upon muscle with the dynamometer and its psychic reaction with Exner's neuramöbimeter, confirming the observations of clinical experience. The failures, or want of effect, so often noticed with coca itself, find ready explanations in the statement of Merck that the quantity of cocaine contained in various samples of coca leaves varies between 0.2 and 0.02 per cent. So uncertain have been the results of the use of coca in its various preparations that it has been practically abandoned in the treatment of morphinism except as one of the agents *ut aliquid faciat*, among which numerous preparations the conscientious practitioner would select one which had received some sanction in the treatment of the special disease. Moreover, the various unknown changes which the alkaloids undergo in the stomach, together with the more sluggish absorption, and the cost of the drug, give good reasons of support for the clinical experience that the only certain speedy and effective mode of administration is by the hypodermatic method. It is best at first to combine the cocaine with morphia, the muriate of each alkaloid preferably, commencing with a grain of cocaine and whatever strength of morphia may be considered best in the individual case, having especial reference to the quantity of morphia used, and then gradually withdraw the morphia. An approximate idea of the quantity of morphia that has been in daily use may be learned, if concealed, from the effects of the cocaine, as the more exhilaration or euphoria produced, the less has been the quantity of morphia.

It is necessary to continue with the cocaine for several weeks after the morphia has been withdrawn, for Burkhardt has shown that the so-called abstinence symptoms, excitement, unrest, neuralgias, chills, sweatings, insomnia etc., with unappeasable cravings for the drug, may set in after two months of abstinence. Opium is known to remain a long time in the body in intimate union with the protoplasm of nervous tissue. Stas claims to have found morphia in bodies after 13 months of inhumation, and Drag-

endorff and Kauzmann have shown that, mixed with moist organic matter, morphia preserves itself unchanged for months. It is essential here not to confound color reactions with the ptomaines, and to use in case of doubt the test of physiology. Such a mistake was actually made by Sonsegnos, and was rectified by Selmi after the manner mentioned, but this subject does not properly belong to this discussion. The fear of a cocaine habit is quite ungrounded, in fact. That is, there is no fear of danger, or of damage from small doses, and large ones produce effects too immediately unpleasant to lead to any abuse. The statement that the patient will return to his old habits in time is no real objection, as the physician is concerned only with the case in hand at the time and need have no more regard for the future than any other humanitarian, or at least no more concern than in the case of any other disease liable to return, malarial fever, for instance, with a new reception of the poison. During the interval of freedom the will of the patient may be, with proper methods, drilled to better discipline, just as, in time, we may sometimes drill with electricity the few twitchings of a paralyzed muscle to a more perfect tone.

#### CASE OF VARICELLA SIMULATING PEMPHIGUS.

BY W. H. GEDDINGS, M.D.,  
OF AIKEN, S. C.

M. T., a little girl, five years of age, previously healthy, was attacked with scarlatina on the 26th of January. On the 31st the eruption disappeared, and the usual desquamation began. The latter process was exceedingly slow, lasting until February 14th. On the following day a number of translucent vesicles, about the size of a small split pea, appeared on the face and other parts of the body. A few of them were slightly umbilicated, but, as a rule, they were dome-shaped, quite thin, and filled with clear, serous fluid—presenting, in fact, all the appearances of varicella. The diagnosis was subsequently confirmed by the occurrence of several other cases of chickenpox in the same house.

*Feb. 15* (second day of the eruption).—The vesicles are much larger, several of them being fully as large as a hazelnut. The contents of the vesicles have lost the crystalline appearance of yesterday, and become straw-colored. Any one seeing the case at this stage for the first time, and unfamiliar with its previous history, would at once have pronounced it to be pemphigus. She complains of some pain and considerable pruritus.

*16th.*—Pulse 126, but is reported to have been as high as 130. The bullæ continue to increase in size, some of those on the ankle being fully one inch in diameter.

*17th.*—Bullæ still larger, many of them being the size of an English walnut. On the ankle and leg several of them have become confluent, forming an immense bleb some four inches in length, occupying nearly the whole of the anterior surface of the leg, and almost encircling it. On the face and elsewhere there are a few fresh vesicles with clear contents, and

differing in no aspect from those of an ordinary case of varicella. She suffers terribly with pain, and, where the cutis is exposed, the burning is so intolerable that she shrieks with agony.

*18th.*—No new bullæ.

*19th.*—Bullæ drying up.

*20th.*—Shrinkage of the bullæ and drying continue, but there is still some fever, and the little patient is so weak and exhausted with suffering that her hands shake like those of an old woman.

*25th.*—The bullæ and vesicles have all dried and exfoliated. She gradually recovered flesh and strength, and soon became bright and cheerful. At the time of her departure for her home, in New York, several months later, she had quite recovered her usual health.

We find, in dermatological literature, descriptions of varicella bullosa, and of urticaria bullosa, but, to my knowledge, no mention has ever been made of cases of varicella in which the bullæ exceeded an inch and a half in diameter.

#### TWO CASES OF DIPHTHERITIC CONJUNCTIVITIS.

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THE opportunity of studying types of conjunctival inflammation, complicated by a deposit of diphtheritic membrane, is perhaps sufficiently rare to make the following cases worthy of record:

CASE I.—Nellie C., two and a half years of age, was admitted to the Children's Hospital, February 2d, of this year, at that time suffering from a severe attack of phlyctenular keratitis. The course of this disease was unusually stubborn, and many relapses occurred. When the child was finally on the fair road to recovery she contracted measles, which were then epidemic in the Hospital. Her case of measles, although uncomplicated, was very decided, the temperature on one occasion reaching 106° F. During the fever and also during convalescence a marked relapse of the eye troubles occurred; so that, by the time convalescence was fully established, the child was the subject of a most pronounced case of mucopurulent conjunctival catarrh, with ulceration of both corneæ, the surfaces of the upper lids of both eyes and a large area of the surrounding skin of the face being covered with eczematous ulceration. Under treatment these lesions gradually abated until May 23d, about two weeks after the attack of measles, when the eyes in all particulars again put on an angry look.

On the following morning the symptoms were more aggravated, and the conjunctival surfaces of both upper lids were more or less covered with a gray exudation. The same exudate was further present in the mucous membrane of the nostrils, a few patches on the inner surface of the lower lip, and quite generally on the eczematous ulcers of the face, especially on the lower lids, where they were in contact with the under surfaces of the swollen and overhanging upper lids and consequently in contact with the exudation. Further, the upper lids were hot,

tender and rigid, being difficult of eversion. The exudate, which was in, rather than upon, the mucous membranes, could not be wiped off, but was only detached with effort and left beneath a depressed and raw surface. In addition to these local manifestations marked constitutional disturbances were present. The pulse was rapid and feeble, the respiration noisy and frequent, the temperature elevated ( $101^{\circ}$  in the morning,  $103^{\circ}$  in the evening), the tongue brown-coated and the skin harsh and dry.

In two days the membrane slowly changed from a gray to a yellowish-gray color; was more generally present and became more decidedly incorporated with the tissues. The suppuration, which had been so profuse, almost ceased; or, to speak more accurately, gave place to a thin, sanious discharge, intensely irritating, which ran from the eyes and nostrils and excoriated all surfaces with which it came in contact, adding thus to the general discomfort of the child and the disfigurement of her face. The exudation confined itself to the tarsal conjunctiva, leaving the ocular conjunctiva free, although greatly swollen and inflamed.

By the eighth day the disease, or at least its local manifestation, had reached its height, and from that time until the fourteenth day it gradually declined, the swelling of the lids slowly diminished, and the exudation both upon the face and conjunctiva disappeared.

At the present writing, one month after the onset of the disease, its external lesions have passed away. Both corneæ, however, have suffered severely. In each, the spot of previous ulceration has developed into an area of purulent infiltration with staphylococcus bulging, most marked on the left side, but in each also clear cornea remains, and later operative measures may restore fair vision to the child.

In the treatment of this case recourse was had to the following measures:

During the period of the greatest intensity of the local condition warm compresses were constantly applied to each eye. All affected areas were kept as clean as possible by frequently washing with a solution of bichloride of mercury (1:1000), and a solution of atropine (gr. iv-f $\frac{5}{j}$ ) was dropped into the eyes every three hours.

The constitutional treatment consisted in the administration of milk punch, quinine, and iron.

After the second day the child was given five minims of the tincture of the chloride of iron, and  $\frac{1}{18}$  of a grain of bichloride of mercury every three hours and the quinine by suppositories. Variations in the treatment from day to day were necessary, but it is needless to refer to them in detail.

CASE II.—Joe W., aged ten, was admitted to my wards about the first of May on account of keratoiritis of his right eye. He was progressing favorably, when in his left cornea appeared a phlyctenule and later a phlyctenular ulcer, together with some conjunctival catarrh. This was pursuing the usual course of such a condition until May 27th, or four days after the disease in Case I. had appeared, when the eye and surrounding tissues took on great swelling, and an exacerbation of all previous symptoms occurred, especially of the catarrh, which became muco-pu-

lent, or indeed entirely purulent. On the following day the upper lid was still more swollen, the discharge had diminished and a membrane, in all particulars resembling that seen in the case just described, appeared in the tarsal conjunctiva. On the third day the oedema of the upper lid was enormous; the purulent secretion had ceased; the cornea, a view of which could only be obtained with the greatest difficulty, was dull and hazy, "like that of a dead fish," and the membrane almost entirely covered the inner surface of the lids. Under treatment the symptoms gradually subsided, and now no traces of the disease remain, except a faint nebula at the inner margin of the cornea. The right eye, which was scrupulously protected, escaped infection.

In the treatment of this case, during the first thirty-six hours of the disease, iced compresses were applied to the eye and blood was taken from the temple, as the nutrition of the patient was good. These measures produced no appreciable effect, and at the end of that time for the cold compresses were substituted wads made of cotton steeped in water as hot as could be borne by the skin, the application being made for five minutes at a time every two hours. The cutaneous surface of this lid was further painted freely with collodion, with the hope that the contracting film thus produced would, by an even pressure, aid in diminishing the oedema. Strict attention to cleanliness, by the aid of antiseptic washes, was ordered, and mydriasis, by the use of atropine solution, maintained. In addition to these measures supporting food, milk punch, and quinia and iron were administered. The result of this treatment was most happy; the swelling subsided; the membrane disappeared; suppuration was reestablished, and now scarcely any result of the disease remains.

*Remarks.*—It seems reasonable to place the epidemic of measles in direct etiological relation with the development of the first of these two cases. A child of depraved nutrition, disposed to facial eczema, and just convalescent from an attack of acute illness, is the typical subject for diphtheritic inflammation of the conjunctiva. It is further interesting that, in two other instances, this epidemic of measles in the Hospital was followed by diphtheria of other mucous surfaces—the larynx in one case and the fauces in another. In brief, the diphtheritic influence being present, this type of inflammation was the more readily engrafted upon a mucous membrane whose resisting power was lowered by previous inflammation and the effects of acute illness. To a certain extent the same conditions obtain in the second case; but it seems more natural to assume that, inasmuch as the same nurse attended to both cases, although in separate rooms, an accidental, but still a direct inoculation from the original case was the etiological factor. The fact that this attack pursued a much more benign course and recovery was reached without loss of any corneal tissue, is probably explained by the superior nutrition of this child as compared with that of the other.

Many other points in the etiology of diphtheritic conjunctivitis might be dwelt upon, but the whole subject has been so thoroughly investigated that it is only necessary to refer to the classical paper of A.



von Græfe (*Arch. f. Oph.*, I., i. 168, 1854), and the more recent discussion by Mr. Nettleship (*St. Thomas's Hospital Reports*, vol. x., 1880). Græfe, De Wecker, and other continental ophthalmic surgeons, have made a distinction, more or less sharply marked, between diphtheritic and membranous ophthalmia; while Nettleship, and more recently Juler, are disinclined to maintain this distinction. Be this as it may, it seems proper to classify the two cases just reported, by virtue of the course they pursued and the pathological lesions which they exhibited, as instances of true diphtheritic conjunctivitis.

I have to thank my colleague, Dr. B. Alexander Randall, for his assistance in the treatment of these cases; and also Dr. S. D. Risley for valuable advice, he having kindly seen the cases with me during a brief absence of Dr. Randall from town.

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## MEDICAL PROGRESS.

DIABETIC GLYCOSURIA IN OLD MEN.—DR. LANDRIEUX and H. ISCOVESCO reach the following conclusions relative to diabetic glycosuria in old men.

1. There is no reason to establish any essential difference between the terms glycosuria and glycosuric diabetes.
2. Senility gives to glycosuric diabetes special characteristics.
3. Senile glycosuric diabetes is ordinarily presented under the form of intermittent or remittent attacks.
4. Senile diabetes is frequently accompanied by other disorders of assimilation, as shown by azoturia, albuminuria, and the presence of the bile pigments.
5. The various mal-conditions observed in old men may be explained by a general ataxia of nutrition.—*La Progrès Médicale*, June 27, 1885.

FERRÁN'S CHOLERA INOCULATIONS.—Whatever may have been the attitude, whether of hope, of incredulity, or of suspension of judgment, which scientific men at first assumed with regard to Dr. Ferrán's alleged discoveries of the complete life cycle of Koch's bacillus, and of the immunity conferred by inoculation with it, he has, by his conduct towards the French Commissioners, headed by no less eminent a physician and sanitarian than Dr. Brouardel, completely put himself out of court, and thrown away all claim to the sympathy and support of the profession.

The disease that Ferrán induces in his subjects appears to be identical with, though happily for them milder than, that which Thiersch in his well-known experiments produced in mice, and which is now very properly held to have been a form of septicæmia, and not cholera at all; but that was in the dark ages of microzoic pathology.

But even supposing it were possible, as it may yet be found, to induce cholera by the injection of bacilli or their products, there is no ground whatever for imagining that it would confer immunity. It is true that those specific diseases, smallpox, measles, etc., one attack of which, as a rule, protects against a subsequent infection, and in which, therefore, artificial infection holds out a greater or less probability of a like immunity, do occa-

sionally recur; but we have, considering the high mortality, the irregular distribution and the long intervals elapsing between epidemics of cholera in Europe, a number of instances of persons being again attacked, quite sufficient to justify the belief that one attack does not in any way protect against the disease in future, and that *à fortiori*, its inoculation, if practicable, would be utterly inoperative. Without repeating Jenner's experimental inoculations of smallpox after vaccination, persons are continually of necessity and in the path of duty exposed to risks and circumstances under which they must certainly have, in many cases, contracted the disease had not vaccination conferred protection. But in the case of a disease not contagious in the ordinary sense, as enteric fever or cholera, such conditions do not occur, and direct crucial experiment, as drinking the stools, being obviously inadmissible, it is difficult, if not impossible, to say that even some out of numbers of persons operated on must otherwise have been attacked. Protection, even as Ferrán asserts, for a few weeks is a pure assumption; indeed, the idea of temporary immunity requiring a repetition of the operation is entirely without analogy, and seems a mere device to obtain repeated fees.—*Medical Times and Gazette*, July 18, 1885.

THE CONTEMPORANEOUS USE OF IODIDE OF POTASSIUM AND CALOMEL.—A writer in *Il Morgagni* calls attention to the ill-effects following the local application of calomel to an ulcerated cornea in a patient who, at the same time, was receiving the iodide of potassium internally. According to the results of experiment upon animals, the reasons for the bad effect observed are that after some days the iodide of potassium is present in the lachrymal secretion, where, uniting with the calomel in the conjunctival sac, the protiodide and biniodide of mercury are formed; the first being irritant, the second exceedingly irritant, and even caustic. It is noteworthy that the same results have been noticed after baths of iodized water.—*Gazzetta degli Ospitali*, July 15, 1885.

NEW EXPERIMENTAL AND CLINICAL RESEARCHES UPON BRIGHT'S DISEASE.—PROF. MARIANO SEMMOLA deduces the following conclusions from the results of his latest experimental and clinical researches upon Bright's disease:

1. Albumen can traverse the renal tissue without any previous alteration in the histological elements of the kidney, and without leaving any trace of its passage.
2. If the passage of albumen is persistent, the first effect is hyperæmia with intraglomerular and intratubular hemorrhage, and the capsule is distended in a mass after boiling, and sometimes is simply raised and separated from the glomerulus by an empty space. There is also observed considerable migration of leucocytes without any alteration of the epithelium. The urine contains hyaline cylinders. These are the first results of an inflammatory action in relation with the functional activity of the kidney.
3. If the functional process persists beyond even eight or ten days, especially with the injection of albumen in the proportion of one gramme for every thousand grammes of the animal's weight, the invading process is attended by a mild inflammatory action, in

addition to a turbid swelling of the epithelium of the tubules, fatty degeneration, and thickening of the intratubular connective tissue.

This proves that the functional activity, which the kidney must sustain in the gradual and prolonged elimination of inassimilable albumen, is apt to provoke successively in different parts of the organ an inflammatory process which, commencing in simple hyperæmia, may result finally in the establishment of interstitial nephritis. Prof. Semmola is convinced by repeating the experiments and injecting very minute quantities of albumen, in order to have the experiments well under control and preserve the life of the dog for seven or eight months, that they will result in producing the last phases of the large white kidney—that is to say, the atrophic kidney.

4. The histological alterations in the kidney persist for some time after the injection of the albumen without producing a continuation of albuminuria.

5. Along with the elimination of albumen with the urine is also observed *albuminocolia*; that is to say, the elimination of a certain quantity of albumen with the bile.

In relation with the above experiments, Prof. Semmola proposes to continue his researches on the pathology of Bright's disease with the following experiments to determine:

1. The comparative influence upon renal elimination produced by the injection of albuminose, which is presumably more assimilable, such as serum of blood, albumino-peptones, white of egg, and milk.

2. The influence of albuminous injections upon the crisis of the blood, and upon the elimination of a quantity of albumen greater than that injected.

3. The influence of albuminose injections upon degree of activity in the combustion of nitrogenous matters and upon the production of urea.

4. The influence of albuminose injections upon the dyscrasic condition of the blood, and their relations with the production of anasarca.—*La Medicina Contemporanea*, June, 1885.

POWDER FOR PYROSIS.—M. PETER in *L'Union Médicale*, July 18, 1885, recommends the following powder in the treatment of pyrosis:

R.—Sodæ bicarb.	. . . .	gr. xl.
Cretæ præcip.	. . . .	gr. xv.
Ext. nucis vom.	. . . .	gr. iss.
M. Div. in chart. No. x.		

S. One three times a day for patients submitted to milk diet with whom the milk does not agree.

If diarrhœa is also produced, the subnitrate of bismuth should be prescribed in doses of ten grains combined with a sixth of a grain of extract of nux vomica, and from one-sixth to one-third of a grain of powdered opium.

LUMBAR NEPHRECTOMY.—MR. CLEMENT LUCAS removed (in Guy's Hospital, on the 14th instant) a distended floating kidney, filled with large calculi, which could be felt through the abdominal parietes. The operation was performed without difficulty through the loin, leaving the peritoneum uninjured. The patient is progressing uninterruptedly towards recovery, her tem-

perature continuing normal as before the operation.—*British Med. Journal*, July 25, 1885.

A CASE OF CORYZA CASEOSA.—DR. BOURNONVILLE reports a case of coryza caseosa, in an old man, 72 years of age, a coal-burner by trade. The patient, since 1882, had been inconvenienced by stoppage of the right nasal fossa, lachrymation of the right eye and violent pain in the right forehead and side of the nose, angle of the eye, upper jaw, and teeth. After a long remission of the symptoms, the pain again returned and invaded also the left side of the forehead.

The patient finally sought admission into the hospital, chiefly for trouble experienced with his eye. Pressure upon the right lachrymal sac caused the escape of a mucous discharge, for which the canaliculi were slit and Bowman's sound daily introduced through the nasal duct. The sound was movable in all directions, and if allowed to remain for a short time was found coated with a dark-brown deposit, nearly half an inch broad.

By this treatment, the lachrymation was diminished, and the patient left the hospital. He, however, returned in a short time, and an inflammatory fluctuating tumor had made its appearance over the lachrymal sac, the contents of which could not be pressed through the canaliculi. Incision gave free exit to considerable quantity of pus. In a few days a fluctuating tumor made its appearance over the left inner orbital angle, by pressure upon which pus was caused to flow from the incision on the right side, but not from the canaliculi of the left side. Incision now was made into this tumor, and shortly two fistulous openings made their appearance at the root of the nose, giving exit to a scanty, thick, ill-smelling discharge. A sound introduced could be moved upwards, inwards, and downwards. When water was injected through one fistulous opening, it escaped partly through the other and partly through the canaliculi of the right side and the nostrils, or through the pharynx into the mouth. The water in passing through the fistulous cavities became turbid, fetid, and contained a quantity of caseous particles. Daily cleansing of the fistulous passages with a 2½ per cent. solution of boric acid, and injection of the nose with a weak solution of common salt, produced no improvement. Examination, in which a little finger was introduced into the right nostril, caused the patient to choke, and to discharge through the mouth several fetid, putty-like masses the size of a walnut. Examination showed that the antrum of Highmore communicated with the nasal passage by a passage easily admitting the finger, and contained similar masses to those already discharged, and easily recognizable by the finger. Little bleeding resulted from examination. By use of the nasal douche, two additional masses were evacuated and free passage of air through the nostrils established, and examination showed the antrum to be free. The left nostril was normal. The fistula on the right side of the root of the nose healed promptly, but that on the left persisted, while the water injected escaped, carrying with it cheesy matter as above. The fistula was accordingly dilated, the periosteum loosened, and the opening in the lower wall of the sinus enlarged, so that thorough cleansing by injection was possible. Examination again made by reflected light through the fistulous

opening, showed that only an inferior crest on the posterior wall of the septum remained,

The discharge of some additional putty-like masses and small pieces of necrotic bone followed the last-named treatment, after which the mucous membrane became clean and natural in appearance, and the wound healed in one week.—*Centralbl. für Chirurgie*, No. 16.

**HYDRATE OF CHLORAL AS A PREVENTATIVE OF THE NIGHT SWEATS OF PHTHISIS.**—NICOLAI, in the *Rif. Med.*, recommends hydrate of chloral in the night sweats of phthisis.

Two drachms of chloral hydrate are dissolved in two goblets of water and brandy in equal parts. In the evening, before going to sleep, the patient is sponged with the mixture.

If such application is insufficient, a shirt, wet in the same solution, is put on the patient during the night, and when removed the patient is wiped dry.

The effect of the remedy is excellent, especially in children suffering with the night sweats of phthisis. Frequently three or four applications are sufficient to cause cessation of the sweats, which persist for several weeks.—*Gazzetta degli Ospitali*, July 15, 1885.

**TUMORS IN ANIMALS.**—MR. J. R. BLAND SUTTON, F.R.C.S., in an elaborate study of tumors in animals, reaches the following interesting conclusions:

1. No tumors are peculiar to man; certain forms occur with greater frequency in him than in other animals, notably the cancers. This may depend on paucity of observations, but the conclusion is warranted by our present knowledge.

2. Sarcomata, fibromata, osteomata, and enchondromata are the most widely diffused of all growths; they occur in fish and all intermediate forms up to man. We have reliable evidence of the occurrence of osteomata in extinct forms; these growths constitute an ancient inheritance.

3. Fatty tumors are almost entirely confined to animals long domesticated,—the ox, horse, sheep, etc.

4. Odontomata are of frequent occurrence in mammals.—*The Journal of Anatomy and Physiology*, July, 1885 (London).

**HYSTERICAL SUPPRESSION OF URINE.**—A peculiar case has been communicated by DR. T. J. GRIBLING, of Waalwijk, to the Netherlands Medical Society, where there was profuse perspiration, accompanied with partial, and, for a time, complete suppression of urine. The patient was a girl of nervous constitution, who was, however, in good health till she was about 12, when she somewhat suddenly complained of extreme fatigue and want of power in the legs. She then began to suffer from violent headache of the left frontal region, which, though persistent, always became especially violent at noon. In the evening, when it abated, profuse general perspiration came on. When the writer first saw the child, this had been going on for some months. There were converging strabismus, and quick respiration and pulse; the temperature was normal, and no organic disease could be detected. The legs were quite powerless, but gave normal electric and reflex reactions. She had not at that time menstruated. The bowels acted

very rarely, and the quantity of urine was very scanty. The food taken was very small in quantity; nevertheless, the girl's weight did not materially decrease. This state of things continued for a year, uninfluenced by arsenic, atropine, and numbers of other remedies which were tried. The suppression of urine then became absolute, and the perspiration still more profuse. The author was careful to remark in the patient's hearing that, when the urine returned, the perspiration would be diminished. In about five weeks' time, menstruation occurred, and a quantity of urine was passed. On this, the girl said to her mother: "Now the sweating will cease;" and, in fact, it did so, and did not return. The urine continues to be passed in satisfactory quantity, but there are still headache and want of power in the legs.—*British Med. Journal*, July 25, 1885.

**A NEW METHOD OF ADMINISTERING PEPSIN.**—DR. PROSSER JAMES recommends the following method of administering pepsin. He says:

In adding another to the numerous preparations of pepsin, it is unnecessary to enter upon its physiological or therapeutical action. Pepsin has conquered for itself an important position in modern practice, and the new preparation is simply designed to render its administration more easy, as well as more satisfactory. The importance of administering it within a short time of taking the food on which it is expected to act has been generally appreciated, so far as giving directions for the dose to be taken a little before or a little after a meal; but too often these directions are not implicitly followed, partly, perhaps, from the prejudice many patients have to take physic with their food; moreover, this plan is ineffectual. In natural digestion the pepsin is not all poured on the food at once. By the movements of the stomach its contents are successively exposed to the action of the gastric juice as they come in contact with the walls. To imitate this we might take pepsin in successive portions; but patients, who mostly think it hard to swallow a single dose of medicine with a meal, will not be easily persuaded to sip it, and they usually object to the taste of the liquids. There are other reasons why some of the preparations in common use are ineffectual. Thus, when taken with strong wines, the pepsin is precipitated, and the vinum is perhaps the worst preparation we can employ.

To secure pepsin being taken at the time it is required—that is, with the food on which it is to act—I have endeavored to convert it into a condiment. At first I tried a sauce, but with less success than I had hoped. Considering that pepsin is so associated in digestion with hydrochloric acid that some have held that a definite compound—pepto-hydrochloric acid—is formed, it occurred to me that, as chloride of sodium is the universal condiment, a combination with that salt offered the most likely solution of the problem I had set myself.

A simple mixture of pepsin with salt may be successfully employed as a digestive condiment, provided it be freshly prepared each time; for such a mixture, if kept, is apt to decompose, and the patient who has once observed this will take no more of the putrefying powder. How to overcome this difficulty was the next problem; and this has been also solved. The pepsin and the chloride must be brought together in such a way that possibly a compound, or pepto-chloride, may be formed.



Whether such union occur or not, a powder thus prepared is quite stable. I have before me now a sample made many months ago, which has been used at intervals at the table in place of common salt. It has a faint color, which is not objectionable, and used as table salt is nearly indistinguishable from that condiment. Here, then, is a digestive condiment, a peptic salt, which many may be glad to try, and which has already given me satisfaction.

I propose to call it "peptic salt," or "digestive salt," or it may be ordered in prescriptions, if preferred, as salt-pepticus, or as pepto-chloride of sodium. Ten grains of my peptic salt will dissolve nearly 200 grains of hard-boiled albumen, or two ounces of lean-cooked meat. It may take the place of table-salt in the dyspeptic's dietary.—*The British Medical Journal*, May 16, 1885.

**TREATMENT OF VOMITING IN THE INTESTINAL CATARRH OF CHILDREN.**—DR. J. M. KEATING recommends the following as a very valuable remedy in the treatment of vomiting in the intestinal catarrh of children:

R.—Sodæ bicarb. . . . . gr. xv.  
 Creasotæ . . . . . ℥ij.  
 Syrupi acaciæ . . . . . f 3ss.  
 Aquæ lavandulæ . . . . . f 3j.—M.  
 S.—Teaspoonful.

As the most valuable prescription for the treatment of cholera infantum, he recommends the following:

R.—Morphiæ sulph. . . . . gr. ½.  
 Acid. sulph. aromat. . . . . gtt. xxxij.  
 Sp. vini gallici . . . . . f 3ij.  
 Syrupi simp. . . . . f 3ss.  
 Aquæ anisi . . . . . q. s. ad f 3ij.—M.

S.—Teaspoonful every hour.—*The Archives of Pediatrics*, July 15, 1885.

**CORROSIVE SUBLIMATE AS AN ANTISEPTIC IN OPHTHALMIC SURGERY.**—M. CHIBRET read a paper before the third session of the French Society of Ophthalmology, in which he pointed out that notwithstanding the benefits that may frequently be obtained from the use of boric acid and carbolic acid, when an antiseptic is required, they frequently disappoint expectation. M. Chibret has for the last eight months employed corrosive sublimate with great advantage. At first he used it in the form of lotions and ointments, but lately he has had recourse to irrigation, the strength of the solution being 1 in 2000, a strength that is well borne by the healthy eye. It may be applied six times daily. In the first instance, M. Chibret employed it in cases of keratitis with severe and extensive inflammation and hypopyon. Struck with the extraordinary diminution in the degree of suppuration, he ventured to employ it in a case of panophthalmia from punctured wounds, and was not afraid to allow the fluid to penetrate into the interior of the eye. He was delighted to find the ophthalmia promptly arrested. In other cases of keratitis the same success attended the use of the remedy. He dwells on the importance of making the jet of fluid impinge with a certain amount of force on the tissue of the cornea and sclerotic, so as to have a certain penetrating power, and so to act not only on the surface but

upon the deeper layers of these membranes. When the eyes are very irritable and the jet cannot be well borne, cocaine may be employed.—*The Practitioner*, July, 1885.

**LOTION IN EXCESSIVE PERSPIRATION.**—PROF. KAPOSI recommends the following lotion in excessive perspiration:

R.—Naphthol . . . . . gr. lxxv.  
 Glycerinæ . . . . . f 3ijss.  
 Alcoholis . . . . . f 3iijss.—M.

S.—Dissolve. Bathe the region which is the seat of hyperidrosis once or twice daily with the solution, and powder with simple starch or with starch and naphthol—2 parts to 100. In the case of profuse perspiration of the feet, put small pieces of wadding sprinkled with this powder between the toes. If baths with the lotion cause erythema, they must be suspended. In phthisical patients, when night sweats are severe, the use of the alcoholic solution of naphthol—1 or 2 parts to 100—frequently produces amelioration of the symptoms.—*L'Union Médicale*, June 27, 1885.

**ON THE IMPORTANCE OF EARLY PARACENTESIS IN THE TREATMENT OF ASCITES.**—DR EDWARD DRUMMOND, in a paper upon the foregoing subject, says:

It was certainly the practice once, and I believe it is still largely the case, to defer this operation too long, and only resort to it as a mere palliative measure, in order to give a few hours or days of respite from the suffering to which the presence of so much fluid in the abdomen naturally gives rise.

I have witnessed a large number of cases of cardiac, renal, and hepatic dropsy, in which all the ordinary routine treatment by drugs, hot-air baths, etc., failed to arrest, by a single hour, the onward march of the disease and its accompaniments; where a laboring heart, a cirrhotic liver, or disorganized kidney, had its difficulties intensified by the mere hydrostatic pressure of a great mass of fluid distending the peritoneal cavity.

Not to mention the increased difficulty, nay, the almost impossibility, of necessary movement, exercise, etc., all absorbent action of the vessels must be reduced to a standstill, every function of digestion, assimilation, micturition, defecation, obstructed; respiration and oxygenation of the blood impeded; the heart's action embarrassed; and the mere weight of fluid rendering compulsory the maintenance of a sitting posture, by day and night, must be fearfully exhausting to a patient in so advanced a stage of disease, in which the blood is so impoverished and so highly charged with the products of arrested secretion.

Proper diet, with a minimum of fluid, and such medicines as acetate of potassium, sulphate of magnesium, nitrous ether, jalap, elaterium, and other hydragogue cathartics, and still more, perhaps, digitalis, casca, or convallaria majalis, are no doubt useful, especially in the early stages, while iodide of potassium with iron and Baillie's pill must not be forgotten. All these, however, and many more similar preparations, will only excite illusive hopes.

If the fluid be removed by *early*, and, if necessary, *repeated* "tapping," followed by well-regulated firm

pressure, then these remedial agents become really potent for good.

It is generally held that such a course of treatment is more especially useful in dropsy dependent upon cirrhosis, but I have found it less successful in cardiac and renal dropsy, and, in a fair proportion of cases, it has proved *curative*, while in all it has diminished the patient's sufferings, and made his invalid state endurable.

Where an advanced form of Bright's disease, a progressive cardiac lesion, malignant or albuminoid disease of the liver, or like inevitably fatal malady, stands behind, it can of course only be a palliative, but it is a *real* one; it robs a necessarily fatal illness of its worst horrors; gives literally a *breathing space*, a respite from unavoidable suffering, and adds some weeks or months of comfort to a doomed existence.

When, however, the ascites depends on a cause which is temporary—wholly removable or capable of becoming stationary—then paracentesis so practised is the chief means of cure. In any case it is impossible to insist too strongly on the importance of an early recourse to it, as adding tenfold efficacy to otherwise impotent therapeutic means.—*The Practitioner*, July, 1885.

**DIAPHORETIC TREATMENT OF NEPHRITIS.**—The *St. Petersburg Med. Woch.*, quoting from *Vratch*, reports the treatment of nephritic patients by N. HESS by wet packs, hot baths supplemented by wrapping in blankets, and hot-air baths, and draws the following conclusions: (1) The least rise of temperature occurs with packs, the greatest with hot baths. (2) While the temperature is found to sink still further twenty minutes after the pack, it remains at the same height for an hour after both the other methods of treatment. (3) After water baths the temperature regains its original height more slowly than after air baths. (4) During the pack the pulse becomes slower; during both water and air baths, on the contrary, it is quickened for an hour afterwards. (5) Under the influence of the pack, respiration is moderately quickened; during both water and air baths it is still more quickened, but subsequently returns to its normal rate more rapidly than after the pack. (6) The most powerful sudorific effects are produced by hot baths, the least powerful by packing. (7) Though the baths are more stimulating, packing soothes the action of the nervous system, brings the patient on better, and produces a subjective feeling of improvement afterwards.—*The Lancet*, June 27, 1885.

**NERVOUS COLIC.**—DR. SHERSHEVSKI, in the *Lyon Medical*, March 1, 1885, reports a number of cases of colic which seemed to be due to a neurasthenia of the nervous elements of the intestinal canal. They were all in intelligent individuals whose work was chiefly mental. These persons suffer habitually from constipation, with abdominal distention and burning eructations, but without loss of appetite. From time to time, under the influence of prolonged intellectual work or of mental emotions, an aggravation of this condition occurs, with the following symptoms: Excessive meteorism with or without a discharge of gas from the bowel, superficial panting respiration, cyanosis, pains in the neighborhood of the liver or in the umbilical region, or shifting, or feeling of weight in the lower part

of the abdomen and severe tenesmus. The attacks subside after some days with the occurrence of copious evacuations. Shortly before their onset the feces become flattened, as if there were an intestinal stricture. The author attributes these symptoms to a lesion of the nervous system producing an intestinal spasm located in the circular fibres of the muscular coat. This theory of the etiology would seem to Dr. Shershevski to be demonstrated by the action of the remedies employed. For, while purgatives increase the pain and constipation, opium and belladonna reduce the meteorism and cure the attacks.—*The Practitioner*, July, 1885.

**TREATMENT OF DIPHTHERIA BY THE HYDROCARBONS.**—DR. DELTHIL, in the *Journal de Médecine de Paris*, gives the following practical exposition of the treatment of diphtheria by the hydrocarbons:

1. If a suspicious contact causes fear of angina maligna, as prophylactic measures, the individual may be submitted to vapors of the essence of turpentine, either by allowing him to respire them from time to time or by impregnating a couch, upon which he should recline, with the substance.

2. If diphtheritic symptoms are manifested, but do not appear especially grave, it will be sufficient to impregnate the patient's room with the vapors of turpentine, by submitting the remedy to a temperature of 140° F., by a warm-water bath.

The turpentine should be crude, and not rectified. Naturally, of course, the quantity evaporated should be proportionate to the size of the room. In a very large chamber numerous evaporating vessels are necessary. In nearly every case such vaporization is sufficient to prevent diphtheritic angina, if used at the initial period of the attack.

3. If after such measures the symptoms become more serious and assume a toxic character, fumigations, by combustion, of gas tar and spirits of turpentine should be practised as follows:

Take about ten drachms of tar and eight drachms of crude turpentine in a metal or earthen vessel. The mixture is then set on fire, and the fumigation thus produced should be repeated every two hours, or at greater intervals when amelioration is produced.

In order that the procedure may be successful, it should be carried out in a small room, in which all the outlets may easily be closed. Into such room the patient should be carried, and allowed to remain a half hour, and then be removed to his own chamber where the evaporation of turpentine should be constantly maintained. If the odor of turpentine, as sometimes happens, is too penetrating, this effect may be obviated by the addition of spirits of lemon or lavender, thus producing a true perfume.

Local applications of lime water or lemon juice should be made at least every hour, day and night. In the same manner a mixture of oil of sweet almonds, spirits of turpentine, lemon or lavender, with the yolk of an egg, and syrup of mucilage, may be used. Ipecac should be used as an emetic when it becomes necessary to rid the bronchi of free diphtheritic exudations. Tracheotomy, if necessary, should also be performed.

The duration of the treatment is commonly from twelve to fifteen days, during which the fumigations

may be practised without danger even in children only a few months old.

Sulphate of quinia should also be employed when systemic intoxication exists, and the temperature of the sick-room should be kept at an elevated point.

**SUPRAPUBIC CYSTOTOMY.**—MR. F. SWINFORD EDWARDS, at the conclusion of a clinical lecture upon the above operation, says: Suprapubic cystotomy is on the whole the best operation for establishing a permanent outlet for the urine in cases of enlarged prostate and contracted bladder, where, the patient having to void on all occasions his urine by means of an instrument, lives in constant dread of the never-ending instrumentation. Of the relative merits of the suprapubic and prostatic punctures in cases of distended bladder with enlarged prostate, it is difficult to judge until we have more cases of the latter submitted to us. Personally, I should be inclined to favor the prostatic puncture on account of the capital drain it provides, and I should not be surprised were it in the future to take the place of both the rectal and suprapubic punctures where the outlet for urine has to be permanent.—*London Medical Times*, May 30, 1885.

**TREATMENT BY SECTION OF HYDROCELE BY THE ANTISEPTIC METHOD.**—MR. EDWARD BELLAMY, in discussing the treatment by section of hydrocele by the antiseptic method, says: The few remarks I make are based upon the results of a considerable number of cases I have treated, both in hospital and in private practice, in the early and later stages of hydrocele, by which latter I mean those which have been repeatedly tapped and in most instances injected. It is hardly necessary to take up space by instancing the individual cases. It is certainly time that the old-fashioned method of tapping and the supposed radical cure by continuous injection was done away with, as painful, dilatory, and generally useless. I claim no originality whatever in this treatment. I desire to call the attention of practitioners to the fact that they should invariably adopt the method of free incision with strict antiseptic precautions, and I cannot understand why it is not more universally carried out. Every surgeon knows of the method, but, as far as I see, contents himself with adhering to the usual proceedings. There is no danger in it. An anæsthetic can be given if necessary, the healing is rapid, the cure almost certain, if not absolutely so. The operation is as follows: The diagnosis, of course, being established, the scrotum should be shaved, and (if the surgeon thinks necessary) the spray used, the tumor is firmly grasped so as to render the parts as tense as possible. A clean sweep through all the scrotal tissues is then made with the bistoury from the cord to the base, and the fluid escapes. Every bleeding vessel, however small, must be twisted or tied most scrupulously, and the interior of the sac carefully examined for any vessel which may have been wounded or have given way. The cavity should then, not too tensely, be stuffed with either lint soaked in 1 in 40 carbolic oil or gauze, and the upper part of the edges of the wound stitched together, including all tissues—I do not see any advantage in stitching the cut edges of the sac to the sides of the wound—a small tag of the contents

being left out of the most dependent part on the contingency of drainage, a pad of salicylic wool placed over all, and the scrotum supported by a cushion between the thighs. In a couple of days the parts may be dressed (under spray, if thought desirable), and the contents of the sac withdrawn. As a rule, considerable contraction of the walls of the sac will have set in, but it is advisable still to introduce the antiseptic material so long as any appreciable cavity exists, and this is generally for about a week in very favorable cases, when it will be found impossible to pass anything into it, and merely the lips of the original wound are left to close. Tubal drainage is, I venture to think, unnecessary. I have not yet met with any untoward constitutional symptoms by adopting this method, which is equally applicable to encysted hydrocele of the cord.—*Lancet*, July 4, 1885.

**A NEW CASE OF CURE OF ILEUS BY WASHING OUT THE STOMACH.**—DR. KUHN, in the *Bulletin Général de Thérapeutique*, of July 15, 1885, reports a case of ileus cured by washing out the stomach.

The patient was a man, aged about 60 years, and for a year previous had been subject to colic with alternate attacks of constipation and diarrhoea. For some time, however, these intestinal disorders had disappeared almost completely, when suddenly, on May 8, 1885, the patient was again seized with colic more violent than he had ever before suffered, and this in a short time was followed by vomiting. Dr. Kuhn was summoned, and found the patient suffering the greatest agony. The last matters vomited had a fecal appearance. Meteorism was considerable, and the hand applied to the belly easily distinguished the tumultuous movements of the distended intestinal coils. Very little gas escaped from the rectum. There had been no stool since the day previous. Nausea was persistent, and the temperature was normal. Treatment was carried out as follows: An injection of warm water was made, and in an hour followed by a second, of about seven drachms of castor oil, neither of which was followed by any result. At intervals of an hour, two hypodermic injections of  $\frac{1}{4}$ th grain morphia were given, and for treatment during the night a potion containing one drachm of chloral was prescribed.

In spite of the use of these drugs, the patient was restless during the whole night. The meteorism still persisted, as did also the nausea. Washing out the stomach was then proposed, and performed with a solution of soda bicarb. in a proportion of 3 to 1000.

The liquid did not return limpid until about two gallons had been used. The same evening, four or five hours subsequent to the treatment by irrigation, gas began to escape from the rectum, with consequent diminution of the meteorism. Though the improvement of the patient was very manifest, no movement of the bowels occurred, and, after waiting twenty-four hours, a second irrigation was made with water and soda bicarb., 6 parts to 1000. An injection of  $\frac{1}{2}$ ss castor oil was administered, and eight granules of strychnia sulph., each containing  $\frac{1}{60}$ th grain, were given, one every two hours. The same evening, movement of the bowels occurred, the meteorism entirely disappeared, and the patient recovered.



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## CHOLURIA.

THE detection in the urine of biliary derivatives—except bile pigment, in the most general sense of the term—has always been imperfect and unsatisfactory. It is well known that Pettenkofer's test for the bile acids, by means of solution of cane sugar and sulphuric acid, so brilliant with the pure bile acids, or with inspissated bile diffused in water, is totally inoperative, even when bile is added to the urine. The determination of the clinical significance of such presence has, of course, been correspondingly unsatisfactory. Clinicians will, therefore, hail with pleasure any method which promises greater certainty than is now had in testing for these substances.

Such certainty seems to be promised by the recent researches of Dr. GEORGE OLIVER, which appear in the third edition of his valuable little book, just published, on *Bedside Urine-testing*, and for which its present title is altogether too modest. In the first place, Dr. Oliver is disposed to consider that Pettenkofer's test does not react directly with the liver secreted salts, taurocholate and glycocholate of sodium, but only with the derived salt, the cholate. Hence, it does not indicate the presence of the biliary salts in fresh ox-bile until the latter have had time to decompose, and thus liberate the cholic acid; but it reacts at once and decisively after the bile has been boiled several hours with caustic potash, a procedure by which the bile-salts are broken up and the derivative, cholate, furnished. This, according to Dr. Oliver, is the reason why Pettenkofer's test acts with inspissated, and not with fresh bile, for the extract is an evaporated product, and the taurocholates are decomposed

by simple boiling. This, too, explains why it fails to afford a distinctive reaction with jaundiced urines, which are highly charged with bile salts.

Dr. Oliver's proposed test is founded upon the physiological fact that when the products of gastric digestion, peptone and parapeptone, which leave the stomach in an acid solution, meet with the bile, they are thrown down in the shape of a tenacious layer over the entire mucous membrane of the duodenum. In like manner a solution of bile salts precipitates acidulated albuminous urine, or urine charged with peptone, and this precipitation of albuminous matter from an acid solution is also caused by the derivative of the bile salts, cholate of sodium, so that acidified albuminous urine becomes a test for bile salts, but an acidulated antiseptic solution of peptone is a readier and more delicate reagent. Such a solution Dr. Oliver makes by adding thirty grains of Savory & Moore's pulverized peptone, four grains of salicylic acid, and thirty minims of acetic acid to eight ounces of distilled water, and filtering to secure perfect transparency.

Now if twenty minims of perfectly clear urine, of normally acid reaction, reduced to a specific gravity of 1008 and containing bile salts in morbid quantity, are run upon sixty minims of the test-solution, a sharply defined, white band of peptone appears at the border between the two fluids; and on oscillating the tube, so as to mix a little of the urine with the test-solution, the upper part of the column presents an opacity, the density of which is proportionate to the amount of bile derivatives present, in marked contrast with the transparency of the urine below. On further agitation, the opalescence diminishes, and, perhaps, finally vanishes, but it is restored on adding more of the test-solution. The precipitate differs from all other urinary precipitates induced by an acidified reagent, in dissolving completely on adding a drop or two of acetic acid, or a citric acid test-paper, and diminishing, but not disappearing, on boiling, but the opacity is not affected by such a degree of warmth as is sufficient to dissolve urates. Further, an insufficiency, as well as an excess of acid interferes with the reaction, as also does an excess of proteids or of the bile salts themselves. Hence the importance of securing the proper proportions, as in Dr. Oliver's formula, and of diluting the urine to be operated upon.

This test, according to Dr. Oliver, is so delicate that there can be readily determined by it, one part of bile salts in at least 18,000 to 20,000 parts of a solution of chloride of sodium. So far he has been unable to find any other constituent of urine which will react similarly; and, although it is true that a concentrated solution of chloride of sodium in the presence of an acid will precipitate a proteid, experi-

ment shows that when the peptone solution is run upon a solution of salt of any specific gravity below 1050, no precipitation takes place. If the urine contains the average proportion of bile salts found in the majority of healthy urines, or less, the reaction is a mere tinge of milkiness, and is, also, not immediate.

In further proof that this reaction with urine points to bile salts as its source, we have the following facts: (1) That biliary salts extracted from the bile produce an identical reaction. (2) That all the secretions, except bile, either do not act on the proteids at all, as saliva, or they dissolve them, as the gastric and pancreatic juices; and that the bile salts are the only constituents of that secretion which possess the property of throwing a proteid out of solution. (3) The test demonstrates that the proportion of bile salts present in normal urines varies in a well-defined degree with the activity of the digestive organs, showing that the agent reacting with the test is intimately connected with the digestive process. (4) Clinical experience.

As to further sources of error, mucin may be eliminated, because this substance in acid solution is not precipitated by the addition of more acid, and when it is thrown down in urine of acid reaction, it is highly probable that the acid added is not the reagent producing it, but merely supplies the requisite degree of acidity to enable the precipitant already present to operate, and in that event the mucin would only indicate the presence of bile salts.

Urates cannot become a source of error since the mode of application of the test, both qualitative and quantitative, requires the urine to be diluted to a specific gravity of 1008, by which solution of the urates is secured. In addition to the reason above given, the reduction in specific gravity to 1008 is done to obviate such fallacious results as are liable to occur in operating with urines of different densities—concentrated urines often simulating an excess, while urines of low specific gravity, though affording a reaction similar to normal urines, may actually contain more than the normal amount of bile salts.

As further conditions of success, the urine, if not perfectly clear, should be made so by filtration; if cloudy from blood, it should be first boiled and then filtered. If alkaline, it must be brought to a normal degree of acid reaction by acetic acid.

Dr. Oliver has also made a peptone test-paper for bile-salts, and applies the test quantitatively, but for the details of this process we refer our readers to the book.

#### MODERN PHYSIOLOGICAL CONCEPTS.

THOSE physicians who acquired their instruction in physiology twenty-five years ago, and who have not given special attention to recent advances in that

science, are somewhat bewildered occasionally by the modern views of which they from time to time catch glimpses in the journals. The very language is unfamiliar—katabolism and katabolism, inhibition and trypsinogen were not mentioned in their text-books or by their lecturers; there seems to be a new chemistry mingled with the matter, and electrical apparatus of more or less complex arrangement seems a necessity at almost every step of modern physiological laboratory work.

To all such, who would like to obtain a general idea of the nature of the change which has occurred without being compelled to make a study of details, the article on physiology in the recently issued volume (xix.) of the *Encyclopædia Britannica* may be commended.

In this article Professor Michael Foster remarks that while the study of chemistry and physics should precede that of physiology, yet the exigencies of life brought the study of man, and so of physiology, to the front before its time; and hence the history of physiology shows many premature and vain attempts to solve physical and chemical problems before the advent of adequate physical and chemical knowledge. One of the first concepts of a living animal was that it is a complex of organs, each having its respective function, and hence the terms "organism" and "organic" came into use as distinctive of living things. On this theory the principal object of physiology was to discover the functions of the different organs, and, as far as possible, to show the connection of these functions with the location and structure of the organ. The simplest possible organ was supposed to be the cell, but presently it was found that simple plasma, with no differentiation into wall and contents, was capable of presenting all the phenomena supposed to be peculiar to life, and hence a new concept arose, viz., that organization is a concomitant and a result of vital action, but not its condition or cause.

Protoplasm, in Huxley's phrase, became the physical basis of life. This protoplasm differs in the relative prominence of one or another of the attributes or powers which are common to all protoplasm—i. e., assimilation, contractility, etc., and these differences are supposed to be connected with corresponding differences in molecular constitution.

A mass of living, active protoplasm is compared to a fountain, the shape of which remains the same, although its constituents are constantly changing.

If we examine a cell of the pancreas we find that during a period of rest succeeding one of activity the cell increases in size, owing to an accumulation of material in the meshes of the network of protoplasm forming the cell. This material thus stored up is not precisely the same substance as that which characterizes the fully formed secretion. The characteristic

constituent of pancreatic juice is a peculiar ferment called trypsin, and the granules which swell the pancreatic cells are not trypsin, but a material which, with a slight change, becomes trypsin, and which is called trypsinogen. This trypsinogen is more complex in composition than trypsin, and in its turn is supposed to be derived from a still more complex body—to be, in fact, a product of the metamorphosis of the protoplasm itself. This intermediate stage may be termed a mesostate, and as a mesostate may occur either in the process of building up or of decomposition, the term anastate is applied to the former, and katastate to the latter; trypsinogen, therefore, is a katastate.

So, also, in the action of a muscle cell there is supposed that a katastate called inogen is formed, and that this inogen is the source of the energy or force produced.

The building up of protoplasm stores up energy, which is set free in the breaking down. The same conception is applicable to nervous impulses, but we must refer to Professor Foster's paper for details. Those who are familiar with modern physiology will best appreciate his very clear exposition of some of the more recent theories, but the paper is not written especially for medical men, and will be enjoyed by any educated thoughtful reader.

When we began this article it was with the intention of commenting on the extent to which modern physiology is beginning to influence practical therapeutics, but want of space compels us to defer this until another time.

#### THE INTERNATIONAL MEDICAL CONGRESS.

RAPID disintegration still characterizes the new organization of the Congress. This week we are called upon to chronicle more resignations, and the list includes one Vice-President of the Congress, three Vice-Presidents of Sections, and several members of Councils. The very large number of appointees who have declined to accept office under the New Orleans committee are all Old Code men, both in principle and practice, and for the most part they are members of the American Medical Association. They recognize the falsity of the issues which were raised at New Orleans and they have promptly placed their emphatic seal of condemnation upon the most disgraceful piece of intrigue which has yet marred the history of that body, and which is in imminent danger of placing an ineffaceable stigma upon the good name of the whole American medical profession.

Although the hollowness of the Code cry has been fully exposed, we still find it being freely used by the new Committee and we learn that a circular, to which signatures are invited, has been extensively cir-

culated through this State, expressing approval of the exclusion of the New Code men from membership in the Congress, and applauding the work of the Committee at Chicago, and it is headed "The action of the American Medical Association endorsed." The first response it appears to have elicited was the resolutions condemnatory of the action at New Orleans which were passed by the Allegheny County Medical Society and published last week, and this week we hear the echo from Texas.

The profession recognizes that on account of recent events there is imminent danger of its not being able to meet the obligations which it incurred by the invitation extended in its name at Copenhagen, and its members naturally look around to see what means can be found to avert the impending disaster which threatens to defile its good name.

The clearest and cleanest way out of the false position into which the profession has been entrapped by the plotters at New Orleans is for all appointees to discredit them completely by declining to accept office at their hands, and thus their organization must, of necessity, collapse. Already this has been largely done, and upwards of one hundred and twenty of the most eminent of their appointees have declined to be tools in their hands, and the sooner the remainder follow suit, the sooner will the way be opened to the profession to redeem its plighted honor.

At an early day THE MEDICAL NEWS will publish a complete list of the new organization of the Congress, showing who have declined to accept office under the new Committee. Gentlemen who have determined to refuse the positions to which they have been appointed, but whose resignations have not been published, are requested promptly to send notice of their intention to this office.

#### THE LAW REGULATING HOUSE DRAINAGE IN PHILADELPHIA.

THE law regulating house drainage in Philadelphia, which was passed by the Legislature of Pennsylvania at its recent session, will enable the Board of Health of that city to extend its usefulness to a branch of sanitary work over which it has heretofore had very limited control. Repeated efforts made within the past two years having failed to induce City Councils to adopt an ordinance having the same object in view as the law just passed, a conference was held between the Master Plumbers' Association of the city and the Board of Health, at which it was agreed to appeal to the Legislature, and accordingly a bill was prepared and forwarded to that body with a petition setting forth the necessity for the adoption of such a measure. The present law is the bill thus presented with slight amendment.



In a former number we pointed out the defects in house drainage and plumbing which have become exceedingly common in this city, mainly in consequence of the want of a proper law regulating such work. A radical change in the prevailing objectionable practices may now be expected. The responsibility of the administration of the law devolves on the Board of Health. This body is given the fullest authority to adopt and promulgate suitable rules and regulations for the construction of house drainage and cesspools, and to provide for the registration of master plumbers and persons engaged in the plumbing business. It is authorized to establish a system of inspection and supervision over all house drainage, etc.; and, any violation of the rules and regulations it may adopt, is made punishable by severe penalties, and even by imprisonment.

In adopting regulations governing the business the board has the advantage of the experience of other cities which have already established a system of house drainage, and will thus be enabled to avoid mistakes which are apt to be committed by the inexperienced in any undertaking. The authority conferred is almost unrestricted, and it remains for the board to use it wisely. The Master Plumbers' Association is in hearty sympathy with the new movement, and may be relied upon to assist in the work of organization. It is to be regretted that cesspools in present use are excepted from the provisions of the act. It is said that this provision saved the bill from defeat, as there is a strong opposition among the people to any measure which would permit of the extinction of cesspools, which exist in great numbers in Philadelphia. Permanent cesspools, as forming a structural portion of the dwelling, are almost invariably nuisances, and ought to be superseded wherever sewers are accessible. It is not necessary, nor is it practicable to sweep these structures out of existence at once; but the regulations might have been framed so as to cause them to be abandoned gradually, without imposing too severe a burden upon any one. However, as the law stands, it is an exceedingly valuable addition to the sanitary statutes of the city, and its vigorous and wise enforcement will undoubtedly be of immense advantage to the public health.

#### A SUBSTITUTE FOR EMMET'S OPERATION.

DR. CORTIGUERA discusses Emmet's operation, in a paper recently presented to the Obstetric and Gynecological Society of Paris, an abstract of which is published in the July number of the *Archives de Tocologie*. He states that Emmet and those who have repeated, or who have parodied, his doctrines, say that in labor a fissure, of greater or less extent, occurs in the lips of the uterus, and that this lesion causes different disorders which constitute morbid

entities, more or less grave, and the only remedy is to revive the disjointed surfaces and unite them.

It is not necessary for us to say that this is not a fair statement of Emmet's views—but so far as the parodists are concerned, it may be true.

Cortiguera divides tears of the neck of the womb into three classes; the first and most frequent of which produces general disorders; the second, general and local, while the third causes neither. He rejects all operations until a faithful trial has been made of other means for the cure of the disorders arising from the tear. But, if these fail, he substitutes for the suture amputation of the neck. This is certainly one of the strangest of recent professional vagaries, and needs but to be stated to insure its general condemnation.

### SPECIAL ARTICLE.

#### FERRÁN'S CHOLERA INOCULATIONS.

PROF. VAN ERMENGEN contributes to the *Deutsche medicinische Wochenschrift*, of July 16th, the following report of his visit to Spain to investigate the cholera inoculations as practised by Dr. Ferrán.

Permit me to premise, he says, that my mission to Spain has not been so successful as I anticipated. The obscurity which surrounds many of the so-called inoculations I am unable to clear up. I trust, however, that it will be evident that the blame therefor does not entirely rest with me.

I came to Valencia on the 19th of June, in company with my friend Dr. Paul Gibier, assistant at the museum, who, like me, was sent by his government to study the methods of Dr. Ferrán. Our mutual aim, as well as our observations, have resulted in this—that the data which I collected in Spain have been brought together with the assistance and collaboration of this eminent bacteriologist. I may also say that my conclusions in no matter of importance differ from his.

As Dr. Ferrán was in Madrid at the time of our arrival, we endeavored, first of all, to obtain some certain information as to the character of the epidemic. In the city, as well as in the hospital, we had the opportunity of seeing numerous cases, which were undoubtedly Asiatic cholera of the most terrible form—the asphyxic, dry cholera. Koch's comma-bacillus, in two autopsies, was found in the intestinal fluids, and in the stools of the sick in every case. I send you a culture, three generations in Agar-agar, in which you will recognize that the microbes isolated by us are identical with that discovered by Koch.

We have questioned and examined about three hundred persons who were inoculated and reinoculated. The phenomena which were observed after inoculation with Ferrán's vaccine, may be enumerated as follows: About five hours after the injection on the external portion of the upper part of the arm there appears an oedematous swelling, somewhat painful and ordinarily with little extension of swelling. This disappears in from twelve to twenty-four hours without leaving any traces or scar. At the same

time there are observed symptoms of fever, malaise, chills, and a kind of stupor—symptoms which soon pass away and are always proportional to the local inflammatory action. In rare cases (about two or three) two or three liquid stools were observed without specific character. There were no pains or persistent cramps, but sometimes transient contractures. None of the cases observed showed symptoms even suggestive of algidity.

Blood taken from the index finger twelve hours after inoculation, in six tests was normal and contained no micrococci or bacteria. Even at the seat of the oedema—a centimetre from the periphery, the appearance of the blood was normal. In plate-cultures some drops in 10 cubic centimetres of 10 per cent. nutritive gelatine, there was no development of microorganisms. The liquid stools which one of the inoculated individuals afforded, we were unable to investigate.

The individuals who were subjected to revaccination with the second vaccine presented the same local symptoms. The latter appeared to us, ordinarily to be less severe, but it is probable that the method of inoculation which is distinct in each case, is the cause of the difference observed. The first vaccine was inoculated in our presence by deep injection into the muscular tissue, while the point of the hypodermic needle was inserted almost perpendicular to the bone deep into the arm. The method of reinoculation was, as we have found, the same as is ordinarily practised, by which the fluid is injected through a fold of the skin into the connective tissue.

I must add that we did not observe that the slightest precautions were taken to prevent the access of the germs from the air to the vaccine fluid. The vaccine was kept in an unsterilized cup, and was protected from air germs only by a single sheet of blotting paper. The syringe itself was sterilized, as it was called, by drawing a little boiling water through it. Dr. Ferrán neglects all the precautions which are observed in the laboratory in the inoculation of the lower animals. We should not, therefore, have been surprised if we had seen septicæmic appearances follow the inoculations, confirmatory of the reports which lately appeared in the *British Medical Journal* and *Deutsche med. Wochenschr.* I must, however, say in the interest of truth that in no case did we observe abscess or suppuration as a result of the vaccination. Scrupulous investigation concerning a case reported in Alcira, convinces us that the confidence of the correspondent of the *British Medical Journal* was abused. The Chinaman whom he there saw, was seized with cholera without having been vaccinated. A woman, the sister of Dr. Serra, in whom the reporter of the article in question had observed the development of gangrenous abscesses, suffered nothing else than a slight suppuration, which now has left a scarcely perceptible scar. In a letter in *las Provincias* of June 26th, a journal of Valencia, our esteemed correspondent from Alcira assures us that only seven or eight cases of abscess occurred in 10,000 inoculations. Ferrán denies responsibility for these and attributes their occurrence to negligence on the part of his assistants.

Alcira was the first region which the present epidemic of cholera visited. The town is situated upon an island which is formed by the meanderings of the river Jucar. The surroundings are in the highest degree conducive to that insalubrity which is specially noticeable in sundry regions of this portion of Spain. The influence of the water in causing the spread of the disease appears indisputable. As soon as the inhabitants began to drink water from a spring at some distance from the town, the epidemic decreased notably in intensity. The register of inoculation statistics and their results were furnished by the Spanish magistrates. In Alcira from the 18th of May to the 25th of June, 10,000 persons were inoculated—a number representing one-half of the population, which can be estimated at from 20,000 to 25,000—while the latest official census gives only 16,000. The cholera in two months claimed 130 victims—of whom 120 were not vaccinated, and ten had been vaccinated once or twice. This in comparison with other localities, as Burjasol, Murcia, etc., is an extremely small mortality, and shows, with far-reaching significance, that the statistics of Alcira were made to demonstrate the utility of Ferrán's vaccinations. We could obtain no detailed information concerning the social standing of the inoculated and the non-inoculated, concerning their age and sex, and concerning the time when the inoculations took place. It seems probable that the inhabitants of the better classes were vaccinated in great numbers, and for about a month.

In Algemesi, Alberique, etc., the statistics are still less significant.

I now come to the most difficult part of my investigations.

We must next convince ourselves of the presence of Koch's comma-bacillus in Ferrán's culture fluid. A drop of the fluid taken from one of eight balloons which were for the second vaccination enabled us to confirm the presence of Koch's bacillus, unmixed with other organisms. The bacilli were rather sparse, slender, and very small. And there existed none of the forms of development such as Ferrán claims to have discovered. In plate cultures we confirmed the presence of numerous small colonies of normal appearance. We observed that Ferrán's culture fluid was not very favorable to the development of cholera microbes, and that those which were in it quickly perished.

Dr. Ferrán later was very anxious to show us in older cultures the foreign forms which he had discovered in the cycle of development. He exhibited to us in bouillon fourteen days old, and much changed in appearance, voluminous mulberry-shaped bodies, which were five, or even ten times as large as a blood-corpuscle, which he assumes arise directly from endogenous spores of the comma-bacillus! These masses (Ferrán's mulberry-shaped bodies) resemble the concretions produced in uric acid salts by artificial change, and are readily dissolved in great part by hydrochloric acid and acetic acid. Other round, but less voluminous corpuscles which were found in the liquid, correspond, according to Ferrán, with free spores that had not developed so much. It is super-

fluous to say that these forms of impurity are to be ascribed to an origin entirely different. The morphological studies which I undertook under the direction of the author, which he described and illustrated in the *Zeitschr. für klin. Med.*, 1885, led to no result. Ferrán asked more time than we had at our disposal to show us the several forms, and it seemed superfluous to us to pay further attention to the matter.

Even less did I have opportunity to study with Dr. Ferrán the globular masses to whose existence in stages of development of the comma bacillus I first called attention, and which I to-day still consider forms of development, and which are entirely distinct from the exaggerated changes which occur in the exhausted cultures. These are the forms which Ferrán has falsely pointed out as oögenous and oöphorous. I have, in my work, *Researches Concerning the Microbes of Cholera*, already considered these, and think, with my colleague and friend, Dr. Hueppe, of Wiesbaden, that they are very probably reproductive organs and which may be compared with the arthrospores.

I was very much surprised to see that Dr. Ferrán made no use of the perfected means for microscopic investigation of bacteria in the delicate morphological researches with which he was occupied. And every body will be the more astonished, as was I, when I say that he possesses no objective with homogeneous immersion, and Abbé's condenser, and that he omits to stain the bacteria which he studies. His methods of culture, also, are not beyond criticism. However, in order not to digress too widely, I will not make further reference to such points.

We submitted to Dr. Ferrán a series of questions in writing, the solution of which seemed to us indispensable before proceeding experimentally with the procedure which Dr. Ferrán employs in the preparation of his vaccine. To our great regret, Dr. Ferrán declined to answer these questions. He sent us word that it did not seem to him that the time had yet come to publish "his secret," and that he, in his own time and in his own work, would announce the same, and that this was lying in readiness to be sent to the Academy of Science in Paris.

This decision, which simplified our mission in such an unexpected manner, compelled us to abandon the further study of an arranged series of control-experiments. We are compelled to announce that we then requested Dr. Ferrán to supply us with a sufficient quantity of vaccine to carry out a series of experiments upon ourselves and upon animals. We had undertaken to institute comparative experiments concerning the operation of sterilized vaccine, or in that freed by filtration from microorganisms—in contrast with that subjected to no such measures—and we pointed out to Dr. Ferrán that these experiments would in no way render it possible for us to reveal his secret, which he wished to guard, in view of its publication *in toto*.

I may here add that the method of attenuation has already been given me by Dr. Ferrán himself by letter, and apparently consists in cultivating the degenerated microbes in a long series of cultivations of bouillon mixed with gall. We promised Dr. Ferrán, so far as the method of attenuation was new and

different from that known to us, to pledge ourselves in writing not to reveal it before receiving permission from him, but without result. In the light of such treatment, which probably is, not entirely without precedent in bacteriological science, we took our departure from the Spanish bacteriologist. The experiments which we were prevented from making in Valencia are in progress at the laboratory of the Museum for Comparative Pathology in Paris, and I shall probably report them at another time.

## REVIEWS.

LECTURES ON DISEASES OF THE NERVOUS SYSTEM, ESPECIALLY IN WOMEN. By S. WEIR MITCHELL, M.D. Second edition, revised and enlarged, with five plates. Philadelphia: Lea Brothers & Co., 1885.

WE are glad to welcome a new and revised edition of this work, which occupies a unique position among treatises on the nervous system. It is the outcome of an experience singularly rich in those obscure and complex hysterical affections so grievously troublesome to the ordinary practitioner and so difficult to combat by ordinary therapeutical means. Thirteen of the seventeen chapters are devoted to the manifold forms and phases of hysteria, two to chorea, one to tremor, and one to chronic spasms. Three new sections have been added: On Hysteria and Organic Disease of the Spine; On Hysterical Joints; and On the Rectum and Defecation in Hysteria. A remarkable case is recorded of hysterical knee with plastic infiltration of connective tissue outside the capsule, which, as the author remarks, is full of instruction to those who believe that hysteria never gives rise to organic changes. The case reported in Lecture XIV. is of unusual interest, showing how completely hysteria may simulate profound organic disease of the spine—in fact, all the features of local myelitis and degeneration were present, and yet under appropriate treatment the patient recovered completely. The concluding lecture is upon the management of these severe cases by seclusion, rest, massage, and feeding—a method which, rightly carried out in appropriate cases, has proved so remarkably successful in the hands of the author and others.

## SOCIETY PROCEEDINGS.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

*Stated Meeting, June 4, 1885.*

THE PRESIDENT, B. F. BAER, M.D.,  
IN THE CHAIR.

BINIODIDE OF MERCURY AS A DISINFECTANT IN  
OBSTETRICS.

DR. E. R. BERNARDY said that his attention was first attracted to the use of the biniodide of mercury as a germicide by Dr. Miquel, who published in *L'Annuaire Meteorologique de 1884*, the results of some experiments made to determine the minimum amount of a disinfectant necessary to prevent fermentation in a litre of sterilized beef-broth. His experiments show that the mercurials are the best antiseptics, the biniodide being nearly three times as strong as the bichloride. In his



table of disinfectants, he places the bichloride the fourth on the list. To a litre of sterilized beef-broth, he found it required 0.025 gramme of the biniodide of mercury to keep the broth pure; while 0.070 gramme of the bichloride of mercury was necessary to produce like effects. This shows that bacterial life is impossible in a solution of one-forty-thousandth part of the biniodide, while of the bichloride it requires the one-fourteen-thousandth part. I was so forcibly impressed with his experiments that I determined to give the biniodide of mercury a trial in obstetric cases where it would be necessary to use an antiseptic. The following are the cases in which it was used.

*Case I.*—On February 7, 1885, I was requested to take charge of Mrs. I., who had been confined about six weeks previously. It had been her second confinement, the duration of labor had been short and delivery natural, but an extensive laceration of the perineum had occurred. No attempt had been made to bring the parts together by sutures. On the third evening she had been attacked with severe frontal headache and chills, followed by fever with great tenderness over the region of the uterus. There being no improvement in her condition, her medical attendant was discharged, another called in, who gave such an unfavorable prognosis, that he also was requested to cease his attendance. I was finally called in on the above date. The patient had well-marked symptoms of septic poisoning, pulse 130 to 140, small and thready, and disappearing under pressure of the finger; temperature  $104^{\circ}$ – $105^{\circ}$ ; slightly delirious, constant vomiting, abdomen swollen and excessively tender; uterus enlarged, extending fully three inches above the pubis. In the right side there seemed to be a growth extending up into the abdomen, tender on pressure. On making a vaginal examination, I found the os dilated so that my index-finger could readily enter the uterus. Its withdrawal was followed by a gush of highly offensive matter. The uterus was surrounded by organized lymph, and was immovable. The mass on the right side was easily detected, and was continuous with the lymph surrounding the uterus. The vagina was hot. The perineum was torn to the anus; the surface raw and secreting an acrid matter, which scalded the surrounding parts. The urine was dark, on straining a reddish material settled to the bottom, it looked like blood-corpuscles. Dr. A. E. Roussel examined the specimen and reported it to be slightly acid, no albumen or sugar; under the microscope, occasional pus-corpuscles, and swarming with bacteria. In conjunction with internal treatment, intrauterine injections were made three or four times a day. I first used a solution of bichloride of mercury one to two thousand. This was continued for three days without any marked results. The discharges continued as offensive. On the fourth day the bichloride was discontinued and replaced by a one to four thousand solution of biniodide of mercury. Within twenty-four hours an amelioration of all symptoms took place, the pulse fell to 100, temperature to  $101^{\circ}$ , urine became clear, and the discharge odorless. The injections were continued for ten days, their frequency being gradually reduced. The uterus returned to almost its normal size and the lymph was gradually absorbed. The patient recovered.

*Case II.*—March 19, 1885, I was called to attend Mrs.

W. in her first confinement. On my arrival, found she had been in labor several hours. Examination showed the os perfectly dilated, bag of water protruding, vertex presentation, first position, ruptured the amnion. The vagina near its outlet was roughened with venereal warts; these spread also over the vulva. Labor progressed rapidly, and the second stage was happily ended. After waiting nearly an hour, making compression on the uterus, I made slight traction on the cord, and while doing so, felt, with my hand upon the uterus, a cup-like depression of the fundus take place. This convinced me that I had an adherent placenta to deal with, and it would be folly to wait any longer. On introduction of the hand, I found the placenta completely adherent; one could hardly say which was uterus, which placenta. After considerable trouble I at last succeeded in detaching the placenta; it took fully an hour. On making a second examination to ascertain if all had been removed, my hand came in contact with long shreds hanging from all sides of the uterus; the more I scraped, the more there seemed to be. I gave the patient  $\frac{f3ij}{\text{of}}$  of the extract of ergot. The patient did well for two days, when, toward evening, she complained of a chill and severe frontal headache. I gave her quinine sulph., gr. x, with morph. sulph., gr.  $\frac{1}{4}$ , at one dose; washed out the uterus with a 1 to 4000 solution of biniodide of mercury. The pulse was 115, and temperature  $102^{\circ}$ . The discharge was highly offensive. The injections were repeated every four hours. On the evening of the next day the pulse was 98, temperature  $100^{\circ}$ , discharge odorless, and the patient was perfectly well in ten days more.

*Case III.*—April 23, 1885, I was requested to call at once to see Mrs. K., who was reported in imminent danger of death; this was her ninth confinement. The history of the previous ones, with one exception, was not good. Her labors were natural, but were followed by terrible flooding and protracted convalescence. I found the patient in an attack of puerperal convulsions. I gave at once grs. xxx of potass. bromide and grs. xx of chloral hydrate. This dose was repeated in half an hour. Ten minutes later another convulsion occurred. I then bled the patient freely. The os uteri was somewhat enlarged, the cervix soft and dilatable, vertex presentation. Dr. Curtin, whom I had sent for, having confirmed my opinion, and considering that the patient's time was quite up, we decided to etherize, dilate the cervix, and deliver. The forceps were applied, and traction made at intervals. A living child was safely delivered. Continuous pressure was maintained over the uterus; but, after the expulsion of the placenta, the uterus did not contract until it had been washed out with hot water. The bromide and chloral were continued every two hours, and no more convulsions occurred. The patient did well up to the fourth day, when the discharges became very offensive, the pulse accelerated, and slight tenderness existed over the uterus; no chill or fever. The uterus was thoroughly washed out with a solution of the 1 to 4000 biniodide of mercury. Within twenty-four hours the discharge became odorless, and the tenderness over the uterus had disappeared. The patient recovered after a tedious convalescence.

In these cases it will be seen that the biniodide was prompt in its action, markedly so in Case I., where the bichloride and the biniodide were both employed, the

result being decidedly in favor of the biniodide. Naturally it will be said: here are only three cases from which deductions are to be drawn, and yet it is only after it has been carefully used in a large number of cases that its efficacy can be proved. It is for this reason that I call the attention of the members of this Society who are in a position to give it a fair and impartial trial, and at some future time give the results of their investigations. I have found the 1 to 4000 solution of the biniodide non-irritating. I have used it extensively in my gynecic practice, and in washing out pus cavities, with good results. In it we have a preparation where the smallest amount of drug is used with results far exceeding those of any other antiseptic. On account of the small quantity of mercury, there will be less chance of salivation.

The method I have pursued in making the solution is: Take three and a half grains of the salt, well triturated in a mortar, and rubbed with one quart of boiling water, slowly added, giving a solution of 1 to 4390.

Since writing the above, I have seen in the *Philadelphia Medical Times*, May 16, 1885, that H. Panas, Eye Surgeon of the Hôtel-Dieu, uses the 1 to 25,000 solution of biniodide of mercury in eye cases. He makes the following statements: "After a number of experiments, I have convinced myself that a solution in water of 1 to 10,000 of the bichloride, or a similar solution of 1 to 25,000 of the biniodide of mercury, is much superior to any other antiseptic solution employed in eye surgery." Here again we have a statement that the biniodide in a smaller quantity is as good an antiseptic as the bichloride.

DR. MONTGOMERY's experience has led him to the conclusion that the bichloride of mercury is far more effective as a disinfectant than carbolic acid. Its introduction into the Philadelphia Hospital was due to Dr. Parvin, who found it very satisfactory. In eighteen cases of puerperal fever that were treated with bichloride injections only three deaths occurred. This success was attributed by the hospital staff to the use of the bichloride. Dr. Montgomery, in private practice, follows the plan of Dr. Garrigues, of New York, and avoids intrauterine injections after labor, but applies pledgets, wet with a bichloride solution, over the vulva, after carefully cleansing away clots and washing the external parts with a similar solution. This sponging is repeated twice every day. In his last term at the Philadelphia Hospital he had only two cases of puerperal fever, one of which commenced twelve days after delivery. The history of Dr. Bernardy's cases shows an equal, if not better, antiseptic in the biniodide of mercury.

DR. J. V. KELLY, some years ago, had several cases of puerperal fever, and about twenty-five cases that got well. The trouble commenced in a case of abortion, in which he did not succeed in removing all of the placenta. He was at the same time attending a bad case of erysipelas, and at that time the relationship of puerperal fever and erysipelas was not known to him. He was on the point of giving up his practice and leaving the town, and he consulted Dr. Goodell on that question. Dr. Goodell discountenanced such action, but advised him, when attending an obstetric case, to remove his coat and roll up his sleeves, and wash his hands and arms well with turpentine, using the nail-brush thoroughly. Since that time he washes his hands in turpen-

tine every day, and again before every case of labor. He also uses a wash of vinegar or carbolic solution before touching a puerperal patient. He has had no puerperal fever or other septicæmic symptoms since that time.

DR. PARVIN said, as a reference had been made by Dr. Montgomery to his having used corrosive sublimate vaginal injections in the cases of puerperal septicæmia under his care in the Philadelphia Hospital in his term of service last year, he would refer to the antiseptic treatment in the cases occurring the present year. When he took charge of the obstetric ward on the 1st of January, he found five recent cases of septicæmia. Two of these patients died. One of the two had apparently recovered, and then was attacked by pneumonia; quite possibly this pneumonia had a septic origin. Then there were at least seven other cases; but all these, as well as three of the original five, recovered. Injections of a solution of corrosive sublimate, 1 to 5000, were used; in all cases immediately after labor. The external parts were washed, too, with a similar solution. This injection was repeated twice a day, in all cases for the first week after labor; while it was used oftener in those having septicæmia. Intrauterine injections were used only when vaginal injections failed to correct the effusiveness of the discharge. But, as is well known, there may be serious, even fatal cases of septic disease, though the lochial flow is not at all offensive.

In private practice, after once washing out the vagina thoroughly with the antiseptic solutions immediately after labor, this need not be repeated unless symptoms demand it; but the bathing of the vulva twice a day with the solution ought not to be omitted. Add, if you please, to this treatment the use of antiseptic napkins, a practice pursued by Dr. Montgomery at the Philadelphia Hospital so successfully, and I think we have taken the most important means to guard against the entrance of septic germs after labor.

He has had no experience with the biniodide of mercury, and does not know that it will supersede the bichloride. The argument in its favor is as strong as these successful cases can make it; but these are entirely too few, as Dr. Bernardy justly says, to prove its value and its superiority. In one of the doctor's cases labor was induced, apparently, on account of eclampsia. Now, is this the best treatment? Obstetricians are by no means agreed, some of the best condemning such treatment. But the subject is not properly before us now, and therefore no further remarks will be made upon it.

DR. MONTGOMERY uses the bichloride solution as an external wash only, not as an injection. He thinks the records of the hospitals in which injections are used will not show as good results as those in which they are omitted, if septicæmia be not present.

DR. WILLARD had a warning to sound with regard to the use of bichloride solutions of stronger grades. He had been using washes and antiseptic dressings made with a 1 to 1000 solution of bichloride; but, in consequence of what was written about the advantages of stronger solutions, he increased the strength of his dressings to 1 to 500, and within twenty-four hours the stools contained bloody mucus, and were small and griping; there was vesication about the wound and around the limb under the dressings. Entirely dry dressings had been used, but they had been moistened

by pus and serum from the wound. He does not see the advantage of using strong solutions in serum, as 1 to 100 or 75. The serum is a decomposable substance, and an uncertain portion of the antiseptic agent is destroyed by it. Weak solutions in boiled water seem more reasonable and answer every purpose.

DR. LONGAKER has been much interested in the third stage of labor, and would like to hear how Dr. Bernardy removed the placenta in the adherent case narrated by him. He has been using Credé's method with great satisfaction. He thinks the hand should be kept out of the parturient canal as much as possible. He does not use vaginal injections after labor, but depends upon outside washes. He finds that the temperature rarely rises during the puerperal period, even after instrumental delivery. He thinks care during the third stage will avoid the necessity for antiseptics.

DR. PARISH agrees with Dr. Parvin's views. He has found a solution of 1 to 1000 of bichloride irritating, and he now uses 1 to 2000 or 5000. Strong solutions cause an appearance resembling erysipelas or inflammation of the derma. Injections are not necessary in every case; when the surroundings are cleanly, and the patient a multipara, he does not use them; but in primipara with contusions or lacerations, and when version or instruments have been employed, he is in the habit of injecting a weak solution of bichloride, especially after delivery; he does not repeat it, but simply washes out the vagina; cleanliness of hands, instruments, and nurse is the most important point. He has never had any trouble in private practice.

DR. BERNARDY, in closing the discussion, remarked that he thought he had a far better antiseptic in biniodide than the bichloride. He had used the former in surgical cases also, washing out pus cavities, and always with good results. He does not use intrauterine washes in every case of labor. He has attended since the first of the year about seventy cases of labor, and he has employed the intrauterine injections in only the three cases detailed. In every case of labor he uses carbolic acid soap to cleanse his hands and arms and the external genitals of the patient. The eclamptic patient had reached or passed her full term, and there was no reason why the child should not be removed. In the case of adherent placenta it was pulled off forcibly, and a shreddy lining was left in the uterus, as no line of separation had formed. He believes the dangers consequent on passing the hand and arm into the uterus and vagina are much exaggerated, and he does not hesitate to do so when the exigencies of the case demand it.

## NEWS ITEMS.

**MORE WITHDRAWALS FROM THE CONGRESS.**—We are requested to announce the following declinations of office under the new Committee: Drs. Hunter McGuire and S. P. Moore, of Richmond, Va., as Vice-Presidents of the Section of Military and Naval Surgery and Medicine, and Dr. James B. McCaw, of Richmond, Va., as Vice-President of the Section of Medicine; Dr. Le Grand N. Denslow, of St. Paul, as member of the Council of the Section of Dermatology and Syphilis.

We are informed that Dr. John L. Atlee, of Lancaster, has declined his appointment as Vice-President

of the Congress, and that Dr. Joseph R. Smith, U. S. A., has declined to serve on the Council of the Section of Public and International Hygiene; Dr. E. S. Dunster of Ann Arbor, on the Council of the Section of Obstetrics and Gynecology; and Dr. Henry Sewall, of Ann Arbor, on the Council of the Section of Physiology.

**THE DALLAS COUNTY (TEXAS) MEDICAL SOCIETY AND THE INTERNATIONAL MEDICAL CONGRESS.**—The following preamble and resolutions were adopted by the Dallas County (Texas) Medical Society, in special session convened, July 25, 1885. The President S. D. Thurston M.D., in the Chair.

*Whereas*, The American Medical Association at its meeting in Washington City, in May, 1884, recognized a general desire of the medical profession of the United States, by adopting a resolution under which a committee was appointed whose duty it should be to extend an invitation to the International Medical Congress, shortly to assemble at Copenhagen, to hold its next meeting in 1887 at Washington City, D. C., and

*Whereas*, The said Committee, by the letter and spirit of this resolution, was fully empowered to act, not only as a Committee of Invitation, but as an Executive Committee as well, and

*Whereas*, The said Committee in pursuance of the objects of the above-mentioned resolution, and duly exercising the unlimited authority delegated to it, enlarged its membership and otherwise provided for the successful holding of an International Medical Congress at Washington City, in 1887, all of which arrangements were considered by us as judicious, and, contrary to what has been charged by some, wholly disinterested as to personal or local aggrandizement, and

*Whereas*, The American Medical Association at its last meeting at New Orleans, did, in our judgment, unwisely and untimely, virtually rescind its former action, which reactionary movement has deranged, if not indefinitely suspended, the work of the original Committee which was satisfactorily progressing, and created an indifference to the Congress among recognized leaders of medical thought and interest throughout the country, and

*Whereas*, There are those who persist in urging the so-called justice of their claims for the organization of the International Medical Congress on a territorial basis, which unfortunate idea has been unwisely further extended by some members of the profession in Texas in a manner calculated to arouse a sectional prejudice, which has little, if any, existence in our State; therefore be it

*Resolved*, That the Dallas County Medical Society deplores what must be considered the present interregnum in the affairs of the contemplated International Medical Congress, brought about, as we believe, by an ill-considered and hasty action at the New Orleans meeting before mentioned; that this Society was fully satisfied with the work of the original Committee, which was composed of able, eminent, and conscientious members of the profession; that this Society repudiates any attempt to inject a sectional feeling into a purely professional matter which has reference to scientific investigations only, and that said attempt, if offered in behalf of the medical profession of Texas, is, in the opinion of this Society, both unauthorized and gratuitous; and



that looking beyond a narrow-minded policy of personal aggrandizement and sectional interest, we heartily commend the recent action of Philadelphia and New York brethren, as well as those elsewhere, who have retired from the Congress until a more dignified and unselfish view of the arrangements can be had; and we pledge them our hearty support and good will in their efforts to advance the interest of the American medical profession in future meetings of International Medical Congresses, where the truly representative medical abilities of our country shall be enlisted uncontrolled by geographical lines or personal preferences.

**"THE ACTION OF THE AMERICAN MEDICAL ASSOCIATION ENDORSED."**—We have before us a circular with the above heading, which, we are informed, has been widely circulated throughout this State. It is signed by Drs. Wm. H. Pancoast, Wm. B. Atkinson, and P. D. Keyser, and is as follows:

"The action of the American Medical Association, at its meeting in New Orleans, in April and May, and in the subsequent action of its Committee at Chicago, in insisting that only those in accord with the National Code of Ethics should become members of the Ninth International Medical Congress, to be held in Washington, D. C., in 1887, is most heartily endorsed; and we will personally do all in our power for the success of the Congress."

Appended to the circular is the request that, if it meet with approval, it be signed and returned to Dr. Pancoast's address.

**THE SPECIAL MEETING OF THE COMMITTEE OF THE AMERICAN MEDICAL ASSOCIATION ON INTERNATIONAL MEDICAL CONGRESS.**—We are informed that "The Committee appointed in accordance with resolutions passed at New Orleans, will meet in special session for the transaction of urgent business" at New York on September 3d.

**PUBLIC OPINION ON THE CONGRESS ORGANIZATION.**—So rapidly did the new nominees in one city after another—Philadelphia, Boston, Baltimore, Washington, and Cincinnati—declare that they would take no official part in the Congress under the new organization, that it became evident that the undertaking was doomed to ignominious failure unless a complete reversal of the New Orleans action could be secured. We have for some time been convinced that nothing short of that would satisfy the profession and restore any reasonable hope for the success of the Congress. We have felt, too, that this end was most likely to be accomplished by getting as full and prompt an expression as possible of the feelings of the profession. Of late it has looked as if these withdrawals, which at first threatened to confirm the wreck of the Congress, would really lead to the radical remedy we have mentioned.—*New York Medical Journal*.

The fact is unmistakable that the present organization of the International Congress seems gradually falling to pieces. Its best and most representative men have withdrawn. Opinions from the other side show that no confidence or sympathy will be felt in the position taken by the American Medical Association. It is useless to deny that, unless something radical is done, the Wash-

ington Congress will be simply a humiliation of American medicine before the world.—*New York Medical Record*.

Seldom has there been such unanimity of opinion upon any matter as we have seen expressed in the medical journals of this country on the proposed International Medical Congress. We need not repeat in detail the well-known story of the appointment of the original Committee by the American Medical Association, with plenary powers to prepare for the meeting of the Congress in 1887; of the opposition which the printed provisional list of officers and members of the Congress met with; of the movement set on foot to reorganize the original Committee, and thus give an opportunity for the admission of some of the discontents to positions in the Congress; of the reorganization of the officers and councilmen of Sections in Chicago in such a way as to distribute the appointments over a larger area of the Union, not failing to "punish" (as they say in politics) original members who had condemned the New Orleans movement, or were New Code men; how some of the active dissentionists were supplied with prominent places in the new organization; how the leaders of the original Committee were compelled by self-respect to resign, and the most prominent members of the original body in Baltimore, Philadelphia, and Boston, promptly withdrew their names, thus withdrawing from the Congress a considerable number of the ablest men in the country. It is a record painful to make, not only because it means that the Congress cannot now possibly be what it could have been under the first organization, but because it shows how large a share of medical politics can enter into the meetings of such a loosely constructed body as the American Medical Association, when designing members choose to exert themselves.—*North Carolina Medical Journal*.

That the recent action of the American Medical Association is sustained by parliamentary usage, does not in any way commend the expediency of its course in view of all the facts. An executive committee of seven most assuredly afforded a better prospect of efficiency in making "all necessary and suitable arrangements for the meeting of such Congress" than one of forty-five members, such as provided for, with the addition of thirty-eight to the original committee under the resolutions of 1884.—*Atlanta Medical and Surgical Journal*.

What will be the outcome of this deplorable muddle it is altogether impossible now to say. The Committee, aided by older and wiser heads than those who have hitherto directed its movements, may look back and find a path which will lead the Association out of its present dilemma, and up to the point of organizing a truly International Congress, alike worthy of its noble aims and of the great guild which bids it come to our land. If the Committee fails—especially if it fails through unworthy ambition, love of patronage, or, worse than all, through greed of office—it will realize before the business is finished, that wreckers are sometimes wrecked, and revolutions are often fatal to their leaders.—*American Practitioner*.

The policy of the Committee was broad and liberal, recognizing representatives of American medicine, regardless of residence and difference of opinion on matters of purely local interest. The Committee appointments, therefore, were made regardless of mem-

bership in the American Medical Association and without respect to differences on questions of medical ethics. After all, the International Medical Congress, organized in the interest of medical science and medical philanthropy, feels no concern whatsoever in the professional policy or politics of the country where a meeting may be held. The work of the Committee, under the circumstances extremely delicate and difficult, was practically well done and, in the main, acceptably, we believe, to the American profession, as well as to a majority of the members of the American Medical Association. However, there were murmurs in various quarters.

Some complained of the Committee for exercising unwarranted authority. However this may be, we believe the Committee acted in good faith and in the interest of the International Congress. The language of the resolution, under which the Committee was constituted, is certainly very wide in its scope and may easily be interpreted as granting full executive power.

Others thought the Committee wanting in propriety to elect its own members to the most exalted positions in the organization. Why should the Committee have gone beyond its own membership, we ask, when its personnel comprised names historical in American medicine, honored by their countrymen and respected abroad?

More objected to the appointments of the Committee on the ground of an unequal sectional representation. "The North, the South, the East, and the West" were arrayed as if we were in the midst of a presidential canvass. This argument had its effect upon a few inflammable minds, but, fortunately, devotees to the science of medicine are not hedged in by sectional lines. We favor the appointment of men who represent American medicine, wheresoever they may reside, whether in the empire of Texas, in California, or in the cities of the East.

The real cause of all this discord arose from a feeling perfectly natural among men struggling for personal or professional preferment. There were not offices enough to go all around, and for this reason only, many men of unquestioned merit were excluded from official connection with the Congress. The justice with which some others were excluded we now realize more fully, since they have demonstrated so clearly their own unfitness for high official positions.

Already, it is painfully evident that it is simply impossible to organize the American meeting of the International Medical Congress upon the plan adopted by the Chicago Committee. Truly, we stand to-day a divided household, and unless some reconciliation can be effected, the failure of the Congress is inevitable.—*New Orleans Medical and Surgical Journal*.

The progress of another week presents a wide-growing distrust of the recent work of the Committee at Chicago. The withdrawal of the appointees of the Committee in Philadelphia, Boston, Baltimore, and Washington has been followed by similar resignations in Cincinnati, St. Louis, Chicago, and in other localities. These declinations have come not only from the gentlemen originally appointed by the first Committee, but, in a number of instances, the appointees of the present Committee respectfully decline to hold the honors awarded to them. Indeed, it seems to be quite apparent that

the gifts of this Committee will go begging unless some unseen power is raised up to prop its waning fortunes. Under existing circumstances it seems clearly the duty of this Committee to abandon its work of reorganization as the most graceful and practical solution of the difficulties which embarrass it. By such a course the Committee would in no sense lose the respect of the American profession. It has been placed in a false position by the American Medical Association. It has been called upon to perform a duty which no similar Committee of the Association can perform under existing circumstances. The present status of the Congress is the result of a false and unnecessary issue which can work no good to the American profession or to the American Medical Association. Its introduction into this discussion was totally unwarranted and unjustifiable. The "Code" issue is not an issue which should be raised in the organization of an International Medical Congress. At previous meetings of the Congress all questions of medical politics have been rigidly excluded, and such should have been the case in the organization of the present Congress.—*Maryland Med. Journal*.

Perhaps it would have been just as well, in the interests of the Congress, had the New Orleans meeting left well enough alone. Unless the *status quo* of the Committee and its appointees before the New Orleans meeting be restored, the prospects of the Congress must be very gloomy. And its restoration is, of course, out of the question, for it behooves the American Medical Association to be consistent above all things, and, besides, it will be difficult to make it understand that its treatment of the original Committee and of the American medical profession, has been anything but eminently fair, honorable, and courteous. Many men of many minds.—*Medical Age* (Detroit).

We had supposed that the meeting of the American Medical Association recently assembled at New Orleans would gladly endorse the acts of its Committee, and say, Well done! Go on and complete the work you have so well commenced. But no, says a narrow clique of agitators, you have left certain States unrepresented, you have neglected the rural districts, and, worse than all, you have ignored a number of us bumptious sore-heads, who are superlatively well qualified for the most responsible positions in the Congress. By some means a majority of those present were induced to vote for a resolution which practically censured, the Committee, and added enough new men to govern the organization for the future.

We cannot help thinking that the method of procedure was, in all respects, unmanly, ungenerous, and unjust; and we sincerely sympathize with that large portion of the respectable body of the profession in the United States, who must feel keenly the humiliating position in which they have been placed. Already this sad business is bearing its bitter fruit. The respectable physicians of grand, conservative old Philadelphia have, in a body, formally declined "to hold any office whatsoever in connection with said Congress, as now proposed to be organized."—*Canadian Practitioner*.

The extracts from the American medical journals, which we print elsewhere, will be sufficient to show that the prevalent opinion in the States is, that the Washington Congress is not only in danger, but absolutely doomed to failure. The leaders of the profession, both

in Boston and Baltimore, have followed the lead of the Philadelphians, and withdrawn from the Congress, and it is not unlikely that their example may spread to other cities, though, indeed, enough has already been done to turn the meeting of 1887 into what an American contemporary, drawing its illustration from our common history, appositely terms a "rump" Congress. The only hope is that the American Medical Association will be startled back to its senses by the strong and decisive action of the profession in Philadelphia, Boston, and Baltimore, and will make haste to retrace its steps. It may be taken for granted that not even the leaders of the malecontents, and certainly not the members of the Association at large, realized that the results of their action would be destruction to the Congress of 1887, and danger to its successors. Such an event was probably far from their calculations. They simply reckoned without their host, *i. e.*, their leaders, and if they are wise, they will cast another reckoning, this time with due regard to the said host.—*London Medical Times*.

The most recent advices from the United States have brought the startling intelligence that there exists in the American medical profession a very serious discord concerning the next International Medical Congress. We do not propose to discuss the etiology of this rupture, for it is quite enough to be called upon to face the fact that it exists. The fact is very grave. Its existence jeopardizes, if it have not already destroyed, the probable success of the forthcoming Congress. Certainly our brethren in the States cannot expect those who have already promised to attend and those who may expect to visit America at that time, to work with enthusiasm in the preparation of any scientific contribution while those whom they propose to visit are divided, and while wholesale secessions of the official executive and of well-known persons nominated to high offices are announced. Nor do we consider it to be either our duty or privilege to suggest a remedy for this exceedingly unpleasant dilemma. It seems to be conclusive that the profession in America at this moment is hopelessly divided on the subject. Already a large proportion of the influential and active scientific men of Philadelphia, such as Bartholow, Weir Mitchell, Da Costa, H. C. Wood, Pepper, Leidy, Stillé, Parvin, and Goodell, and David Yandell, of Louisville, have publicly withdrawn from the organization of the Congress. A like number of distinguished men in New York, such as Loomis, Roosa, Jacobi, Mundé, Agnew, and Emmet, have also either resigned or been dropped, and therefore will not co-operate with the present organization. The outlook, as the matter now stands, is not at all encouraging. One committee has reorganized the work of another up to the point near that of destruction. Moreover, the work of the present committee must be submitted to the American Medical Association in May, 1886; and no one can say to what extent it may also be either overturned or modified in such a way as to impede seriously the labor necessary to be performed before the meeting of the Congress in 1887. Altogether, the position is lamentable, and there is much fear that the acceptance of the invitation to meet in the States may be withdrawn, and the next meeting of the International Medical Congress be held in Berlin or some other great medical centre, pending the settlement of the serious dissensions among our brethren of the United States.—*Brit. Med. Jour.*

**SENTENCE OF EX-SURGEON-GENERAL WALES.**—The findings of the naval court-martial, before which ex-Surgeon-General Wales was recently tried, were made public this week. The Court sentences him to suspension from rank and duty for five years, on furlough pay, and to retain his present number in his grade during that period.

Dr. Wales was tried for culpable inefficiency in the performance of duty, and for neglect of duty.

**THE ILLINOIS OFFICIAL REGISTER OF PHYSICIANS AND MIDWIVES.**—The Illinois State Board of Health is now engaged in revising the "Official Register of Physicians and Midwives." Any notification of changes, omissions, or errors will be regarded as a favor, as the Board wishes to make the coming register as correct as possible.

Address communications to the Secretary State Board of Health, Springfield, Ill.

**OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JULY 28 TO AUGUST 3, 1885.**

DE WITT, CALVIN, *Captain and Assistant Surgeon*.—Promoted to Major and Surgeon, vice Bill, deceased, to take effect from July 21, 1885.

IVES, FRANCIS J.—Appointed Assistant Surgeon, with rank of First Lieutenant, to rank as such from July 25, 1885.

GIRARD, A. C., *Captain and Assistant Surgeon*.—From Department of the East to Department of Columbia.—*S. O. 170, A. G. O.*, July 27, 1885.

EBERT, R. G., *Captain and Assistant Surgeon*.—From Department of Columbia to Department of the East.—*S. O. 170, A. G. O.*, July 27, 1885.

TESSON, L. S., *Captain and Assistant Surgeon*.—Ordered from Fort Stockton, Texas, to Fort Davis, Texas.—*S. O. 90, Department of Texas*, July 27, 1885.

CARTER, W. F., *Captain and Assistant Surgeon*.—Ordered for duty as Post Surgeon to Fort Stockton, Texas.—*S. O. 90, Department of Texas*, July 27, 1885.

POWELL, J. L., *Captain and Assistant Surgeon*.—Assigned to temporary duty at Fort Leavenworth, Kansas.—*S. O. 110, Department of Missouri*, July 30, 1885.

APPEL, A. H., *Captain and Assistant Surgeon*.—Ordered for duty with U. S. troops forming portion of guard of honor over remains of Ex-President General Grant, at Mt. McGregor, New York.—*S. O. 36, Division of Atlantic*, July 29, 1885.

GORGAS, WM. C., *Captain and Assistant Surgeon*.—Granted leave of absence for two months, to take effect about August 10, 1885.—*S. O. 169, A. G. O.*, July 25, 1885.

**OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, FOR THE WEEK ENDING AUGUST 1, 1885.**

FESSENDEN, C. S. D., *Surgeon*.—Leave extended ten days on account of sickness, July 27, 1885.

GODFREY, JOHN, *Surgeon*.—Granted leave of absence for thirty days, July 29, 1885.

IRWIN, FAIRFAX, *Passed Assistant Surgeon*.—To proceed to Richmond, Va., and Wilmington, N. C., as inspector, July 28, 1885.

AMES, R. P. M., *Passed Assistant Surgeon*.—Granted leave of absence for thirty days, July 27, 1885.

**THE MEDICAL NEWS will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.**

**Local papers containing reports or news items should be marked. Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.**

**All communications relating to the editorial department of the NEWS should be addressed to No. 1004 Walnut Street, Philadelphia.**